G.O.C. STAFF RULE ABSTRACT

BOARD:	State Board of Education
SUBJECT:	Educator Licensure
STATUTORY AUTHORITY:	Tennessee Code Annotated, Section 49-1-302
EFFECTIVE DATES:	January 25, 2016 through June 30, 2016
FISCAL IMPACT:	None
STAFF RULE ABSTRACT:	According to the Board, the proposed rule simplifies the licensure system for teachers. The rule is the same as an emergency rule that is scheduled to expire on February 23, 2016, which received a positive recommendation from the Joint Rule Review Committee at its October 21, 2015 meeting.

Regulatory Flexibility Addendum

Pursuant to T.C.A. §§ 4-5-401 through 4-5-404, prior to initiating the rule making process as described in T.C.A. § 4-5-202(a)(3) and T.C.A. § 4-5-202(a), all agencies shall conduct a review of whether a proposed rule or rule affects small businesses.

Not applicable.

Impact on Local Governments

Pursuant to T.C.A. §§ 4-5-220 and 4-5-228, "any rule proposed to be promulgated shall state in a simple declarative sentence, without additional comments on the merits of the policy of the rules or regulation, whether the rule or regulation may have a projected impact on local governments." (See Public Chapter Number 1070 (http://state.tn.us/sos/acts/106/pub/pc1070.pdf) of the 2010 Session of the General Assembly.)

This rule will have no impact on local governments.

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Sequence Number: 10-23-15
Rule ID(s): 6064
File Date: 10-27-15
Effective Date: 1-25-16

Proposed Rule(s) Filing Form

Proposed rules are submitted pursuant to T.C.A. §§ 4-5-202, 4-5-207 in lieu of a rulemaking hearing. It is the intent of the Agency to promulgate these rules without a rulemaking hearing unless a petition requesting such hearing is filed within sixty (60) days of the first day of the month subsequent to the filing of the proposed rule with the Secretary of State. To be effective, the petition must be filed with the Agency and be signed by twenty-five (25) persons who will be affected by the amendments, or submitted by a municipality which will be affected by the amendments, or an association of twenty-five (25) or more members, or any standing committee of the General Assembly. The agency shall forward such petition to the Secretary of State.

Agency/Board/Commission:	State Board of Education
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Revision Type (check all that apply):

___ Amendment
_X_ New
_X_ Repeal

Rule(s) Revised (**ALL** chapters and rules contained in filing must be listed here. If needed, copy and paste additional tables to accommodate multiple chapters. Please enter only **ONE** Rule Number/Rule Title per row)

Chapter Number	**Chapter Title**
0520-02-03	Educator Licensure
Rule Number	**Rule Title**
0520-02-03-.01	General Information and Regulations
0520-02-03-.02	Teacher Licenses
0520-02-03-.03	Licensure, Instructional Leader
0520-02-03-.04	School Service Personnel Licenses
0520-02-03-.05	Occupational Education Licenses
0520-02-03-.06	Out of State Applicants
0520-02-03-.07	Other Special Cases
0520-02-03-.08	Permits
0520-02-03-.09	Denial, Formal Reprimand, Suspension and Revocation
0520-02-03-.10 through 0520-02-03-.94	Repealed

Substance of Proposed Rule

CHAPTER 0520-02-03
~~TEACHER EDUCATION AND LICENSURE~~ EDUCATOR LICENSURE

Repeal/New

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0520-02-03-.01 General Information and Regulations.

(1) Prospective Educators.

(a) Securing a License. The educator shall be responsible for securing a license, verifying its accuracy, maintaining its validity, registering it with the employing board of education, and meeting the requirements of T.C.A. § 49-5-101.

(b) Unless otherwise designated in this chapter, prospective educators seeking initial licensure must hold a bachelor's degree from a regionally accredited college or university, be enrolled in or have completed a state-approved educator preparation program, and meet all requirements regarding assessments and qualifying scores as specified by State Board of Education rules or policy.

(c) Prospective educators seeking initial licensure must meet requirements in at least one area of endorsement.

(d) In-State Applicant for Initial License. An In-State applicant applying for an initial license must apply through the appropriate official of the educator preparation provider.

(e) At the time of application, prospective educators seeking initial licensure must be recommended by an approved educator preparation provider.

1. For applicants who have completed a licensure program, the provider must indicate that the applicant has successfully completed all required components of the program and indicate the area(s) of endorsement for which the applicant has successfully completed requirements. Recommendations must be received within five (5) years of the date of program completion. If a candidate completed a program more than five (5) years prior to the date of the application, the candidate may attempt to secure an updated recommendation from the provider. Educator preparation providers are under no obligation to issue an updated recommendation. Recommendations must attest that the candidate has met current standards for licensure.

2. For applicants who are enrolled in a licensure program, the provider must indicate the area(s) of endorsement for which the applicant has successfully demonstrated content

competency. Verification of successful program completion, including verification of the endorsement areas for which the candidate is recommended, must be submitted by the end of the validity period of the initial license.

(f) Official transcripts of all college credits, bearing the school seal and/or signature of the registrar, must be submitted with the application. These transcripts and forms upon which licensure is granted become the property of the State of Tennessee. Photocopies are not acceptable.

(g) Upon receipt of the applications, transcripts, and results of required assessments, materials will be evaluated and a license will be issued to the applicant or the applicant will be notified of deficiencies.

(2) Licensed Educators.

(a) Duration of License or Certificate. Initial licenses become valid on the date of issuance. The end of the validity period of the license will be set for August 31. The year of expiration is determined by the date of issuance and advances one year on March 1 of each year.

(b) Licensure Expectations. All expectations for licensure advancement and renewal shall be defined in State Board of Education policy.

(c) Change of Name and Address. If a licensed educator changes his or her name or address by legal means, the holder must report such changes to the Office of Educator Licensing within thirty (30) days of making the change.

Authority: T.C.A. § 49-1-302.

0520-02-03-.02 Teacher Licenses.

(1) General requirements for licensure, as defined in Rule 0520-02-03-.01 General Information and Regulations, apply to all teacher licenses.

(2) Licenses Currently Issued.

(a) Practitioner License. Initial three (3) year teacher license issued to applicants who hold a bachelor's degree, are enrolled in or have completed a preparation program approved by the State Board of Education, and have verified content knowledge as defined in State Board policy. The Practitioner License may be renewed once.

(b) Professional License. A six (6) year teacher license issued upon meeting licensure expectations at the practitioner level and completion of an approved educator preparation program. The Professional License is renewable.

(c) Non-Public School Teacher License. A ten (10) year license issued to individuals who qualify for or hold a valid Tennessee teaching license, have current certification from the National Board for Professional Teaching Standards, or hold a valid license from another state. The non-public license only provides license for an educator to work in a Tennessee non-public school. The Non-Public School Teacher License is renewable.

(d) JROTC Teacher License. A five (5) year license issued to active or retired military personnel who seek to serve as junior reserve officers' training corps (JROTC) teachers, based upon a certification of preparation by the branch of the military approving the teacher placement. The JROTC teacher license does not entitle an individual to teach courses other than those designated as part of the JROTC program, consistent with the requirements of T.C.A. § 49-5-108. No other teaching endorsements may be added to a JROTC license. JROTC teachers may earn a teaching

license with an endorsement in a content area through an educator preparation program approved by the State Board of Education. The JROTC Teacher License is renewable.

(e) Adjunct License. A one (1) year license issued to applicants who teach no more than three (3) classes in subject areas of critical shortage as designated by the State Board of Education and who hold a bachelor's degree, have verified knowledge of the teaching content area and have completed a pre-service preparation program approved by the State Board of Education. The Adjunct License is renewable nine (9) times.

Adjunct teachers must meet the following criteria:

1. The applicant must hold at least a bachelor's degree or a master's degree from a regionally accredited institution of higher education that includes at least twenty-four (24) semester hours of credit in the content area in which they will be teaching.

2. The applicant must have at least five (5) years of work experience in the subject(s) to be taught.

3. The applicant must have completed the pre-service portion of an adjunct licensure program that addresses the knowledge and skills in the professional education core and that has been approved by the State Board of Education.

4. A Tennessee director of schools must state intent to employ the applicant for specific subject(s) and course(s) not to exceed three (3) classes and must provide a mentor teacher for the applicant during the first year of teaching.

5. Applicants are eligible for an adjunct license for the specific subject(s) or course(s) indicated on the application in subject areas of critical shortage as designated by the State Board of Education.

6. School systems shall assess the effectiveness of the teachers annually using the evaluation procedures approved by the State Board of Education.

7. Applicants may renew an adjunct license annually but not more than nine (9) times provided that a director of schools states intent to employ and provided that the applicant has received a successful evaluation in the preceding year. Before the first renewal, the applicant must have passed all required licensure examinations.

8. The teacher shall not attain licensure beyond the approved subject(s) or course(s) without successfully completing the state's regular or alternative licensure programs.

(f) International Teacher Exchange License. The international exchange teacher license is a time-limited license designed to allow eligible teachers from other nations to teach in Tennessee schools for up to three (3) consecutive years. The validity period begins on the date all application requirements for the license are met or July 1, whichever is more recent, and expires on June 30, three (3) years later. If the applicant is employed between January 1 and June 30, the validity period begins on the first (1st) day of the month of employment and expires June 30, three (3) years later. If the teacher wishes to remain beyond the third (3rd) year, the teacher must satisfy all requirements for a professional teacher license. Districts that wish to employ teachers holding this license must adhere to State Board of Education policies regarding mentoring and evaluation of these teachers. The International Teacher Exchange License is nonrenewable.

Teachers participating in an international teacher exchange program must meet the following criteria:

1. Hold primary citizenship outside the United States;

2. Hold the U.S. equivalent of a bachelor's degree or higher;

3. Hold a foreign teacher credential in a field comparable to that recognized in Tennessee;

4. Demonstrate proficiency in English;

5. Provide verification from a Tennessee director of schools of intent to employ; and

6. Provide a recommendation by the government of a country with whom the Department of Education has signed a memorandum of agreement or by a recognized international exchange program.

(3) License Advancement and Renewal.

(a) Practitioner License. At the end of the validity period of the initial practitioner license, if the educator has not met licensure expectations, the practitioner license may be renewed once. If the educator has not met licensure expectations at the end of the second validity period, the license will become inactive.

(b) Professional License. At the end of the validity period of the professional license, if the educator has met licensure expectations, the license will be renewed. If the educator has not met licensure expectations, the license will become inactive.

(4) Additional Endorsements.

(a) Licensed teachers must submit qualifying scores on all required, state-approved teacher licensure specialty assessments for additional endorsements.

(b) Licensed teachers seeking to add endorsements may complete an educator preparation program. In some cases, as defined in State Board policy, teachers may add an endorsement by using a test-only.

(c) Licensed teachers who complete programs of study for additional endorsements at education preparation providers in other states may be recommended by the out-of-state provider to the Tennessee Department of Education.

Authority: T.C.A. § 49-1-302.

0520-02-03-.03 Licensure, Instructional Leader.

(1) General requirements for licensure, as defined in Rule 0520-02-03-.01 General Information and Regulations, apply to all instructional leader licenses.

(2) Licenses currently issued:

(a) Instructional Leadership License-Aspiring (ILL-A). Initial five (5) year instructional leader license issued candidates who are enrolled in an instructional leader preparation program approved by the State Board. The Instructional Leadership License-Aspiring is not renewable.

(b) Instructional Leadership License-Beginning (ILL-B). Initial five (5) year instructional leader license issued to candidates who have completed an instructional leader preparation program approved by the State Board and have submitted a qualifying score on the required licensure assessment. The Instructional Leadership License-Beginning is renewable.

(c) Instructional Leadership License-Professional (ILL-P). Five (5) year instructional leader license

issued to educators who have met licensure expectations for advancement from the ILL-B. The Instructional Leadership License-Professional is renewable.

(d) Instructional Leadership License-Exemplary (ILL-E). Eight (8) year instructional leader license issued to educators who have held an ILL-P or Professional Administrator License (PAL) for at least two (2) years and are eligible for the ILL-E as stipulated by State Board policy. The Instructional Leadership License-Exemplary is renewable.

(3) License Advancement and Renewal.

(a) Instructional Leadership License-Aspiring (ILL-A). At the end of the validity period of the initial ILL-A, if the educator has met licensure expectations, the license will be advanced to the ILL-B. At the end of the validity period of the initial ILL-A, if the educator has not met licensure expectations, the license will become inactive.

(b) Instructional Leadership License-Aspiring (ILL-B). At the end of the validity period of the ILL-B, if the educator has met licensure expectations as defined in State Board policy, the license will be advanced to the ILL-P.' If the educator has not met licensure expectations by the end of the first validity period of the license, the ILL-B may be renewed once. If the educator has not met licensure expectations at the end of the second validity period, the license will become inactive.

(c) Instructional Leadership License-Professional (ILL-P). At the end of the validity period of the ILL-P, if the educator has met licensure expectations as defined in State Board policy, the license will be renewed. If the educator has not met licensure expectations, the license will become inactive.

(d) Instructional Leadership License-Professional (ILL-E). At the end of the validity period of the ILL-E, if the educator has met licensure expectations as defined in State Board policy, the license will be renewed. If the educator has not met licensure expectations, the license will become inactive.

(4) Those who hold a Professional Administrator License (PAL) license issued prior to September 15, 2009, may maintain that license until July 1, 2022, at which time the ILL-P or ILL-E license will be required.

(5) Assistant principals, teaching principals, or dual assignment personnel with more than fifty percent (50%) of their responsibilities involved in instructional leadership must be properly licensed.

Authority: T.C.A. § 49-1-302.

0520-02-03-.04 School Service Personnel Licenses.

(1) General requirements for licensure, as defined in Rule 0520-02-03-.01 General Information and Regulations, apply to all school service personnel licenses.

(2) Licenses Currently Issued.

(a) Practitioner School Service Personnel License. Initial three (3) year license issued to applicants upon completion of a preparation program approved by the State Board of Education, leading to endorsement as a school counselor, school psychologist, school social worker, school food service supervisor, school speech-language pathologist, or school audiologist. Applicants must have also submitted qualifying scores on the state required licensure assessment. The Practitioner School Service Personnel License is renewable once.

(b) Professional School Service Personnel License. A six (6) year license issued to applicants upon meeting licensure expectations at the practitioner level, as a school counselor, school

psychologist, school social worker, school food service supervisor, school speech-language pathologist, or school audiologist. The Professional School Service Personnel License is renewable.

(3) License Advancement and Renewal.

(a) Practitioner School Service Personnel License. At the end of the validity period of the initial practitioner license, if the educator has not met licensure expectations, the practitioner license may be renewed once. If the educator has not met licensure expectations at the end of the second validity period, the license will become inactive.

(b) Professional School Service Personnel License. At the end of the validity period of the professional license, if the educator has met licensure expectations, the license will be renewed. If the educator has not met licensure expectations, the license will become inactive.

Authority: T.C.A. § 49-1-302.

0520-02-03-.05 Occupational Education Licenses.

(1) General requirements for licensure, as defined in Rule 0520-02-03-.01 General Information and Regulations, apply to all occupational education licenses, except for the requirement of a bachelor's degree.

(2) Licenses Currently Issued.

(a) Practitioner Occupational Education License. Initial three (3) year license issued to applicants who have met endorsement requirements pursuant to State Board of Education policy and have had content verification provided by the Tennessee Department of Education. The Practitioner Occupational Education License is renewable once.

(b) Professional Occupational Education License. A six (6) year license issued to applicants upon meeting licensure expectations at the practitioner level, completing coursework covering the professional education standards and additional requirements as defined in State Board of Education policy. The Professional Occupational Education License is renewable.

(3) License Advancement and Renewal.

(a) Practitioner Occupational Education License. At the end of the validity period of the initial practitioner license, if the educator has not met licensure expectations, the practitioner license may be renewed once. If the educator has not met licensure expectations at the end of the second validity period, the license will become inactive.

(b) Professional Occupational Education License. At the end of the validity period of the professional license, if the educator has met licensure expectations, the license will be renewed. If the educator has not met licensure expectations, the license will become inactive.

Authority: T.C.A. § 49-1-302.

0520-02-03-.06 Out of State Applicants.

(1) General Requirements.

(a) Tennessee has adopted the provisions of Interstate Agreement on Qualification of Educational Personnel as proposed by the National Association of State Directors of Teacher Education and

Certification (NASDTEC). Participation in this agreement is evidenced by signed reciprocal contracts between Tennessee and other participating states as defined by the Interstate Certification Project (ICP).

(b) Licensure may be awarded to applicants from states which are not parties to the ICP but which are accredited by or affiliated with the national accrediting body with which the State of Tennessee has entered into an agreement on the same basis as those applying from states which are party to the ICP agreement.

(c) Licensure may be awarded to applicants not covered by Paragraphs (a) or (b) above on the same basis as those applying from states which are party to the ICP agreement if one of the following conditions is met:

1. The applicant has received a recommendation from an educator preparation provider which is accredited by the same national accrediting body with which the State of Tennessee has entered into an agreement; or

2. The Tennessee Department of Education has reviewed a state's process for approving educator preparation providers and has found the process to be acceptable for purposes of granting full licensure in Tennessee.

(d) An applicant from a state other than Tennessee must apply directly to the Office of Educator Licensing.

(e) The application for licensure must be accompanied by a set of official transcripts supplied by all institutions attended by the applicant.

(f) An applicant from another state must submit qualifying scores for assessments required by the State Board of Education. Scores must have been obtained within five (5) years prior to the date of application for licensure.

(g) No license or endorsement which requires a Master's Degree or above as part of its requirements may be awarded to an individual not possessing said degree.

(2) Teacher Licensure for Applicants Trained in Other States.

(a) Applicants meeting all requirements will be issued a practitioner license except those who have been certified by the National Board for Professional Teaching Standards who will be issued a professional license.

(b) Licensure will be awarded in all endorsement areas (the areas most similar to those awarded in Tennessee), which are reflected on the full, currently valid licensure credential(s) supplied by the other qualifying state(s) and the area most closely related to the area of certification by the National Board for Professional Teaching Standards.

(c) Applicants with an out-of-state endorsement in a teaching area covering a grade span that is more narrow than the comparable Tennessee K-12 teaching endorsement, shall be awarded the Tennessee endorsement based on parameters defined by State Board policy.

(3) Instructional Leader Licensure for Applicants Trained in Other States.

(a) Applicants who have completed an instructional leader preparation program approved in a state other than Tennessee who have not yet submitted qualifying scores on the required licensure assessment may be issued an ILL-A. Upon submitting qualifying scores, the educator license may be advanced to the ILL-B.

(b) Applicants meeting all requirements will be issued an ILL-B.

(4) School Service Personnel Licensure for Applicants Trained in Other States.

(a) Applicants meeting all requirements will be issued a Practitioner License.

(b) The Practitioner School Services Personnel License will be awarded to applicants who hold a full and valid school service personnel license from another state.

Authority: T.C.A. § 49-1-302.

0520-02-03-.07 Other Special Cases.

(1) Correspondence and Extension Credit. Credit earned by correspondence and extension instruction with a member of the National University Extension Association or the Teacher College Association for Extension and Field Services shall be accepted for licensure purposes to the extent of one- fourth of the amount of credit necessary for the particular license desired.

(2) Experience in Lieu of Student Teaching. An individual applying for a license who holds at least a bachelor's degree may present evidence of three (3) years of successful teaching experience in an approved school or a National Association for the Education of Young Children (NAEYC) accredited early childhood education program at the grade level of work authorized by the endorsement sought in lieu of student teaching.

(3) Military Service.

(a) The duration of a license may be extended from the date of termination of military service for the number of years, not to exceed four (4), which the holder spent in military service during the life of the license. Four (4) calendar months of military service during any school year shall be counted as a full year for purposes of extending the license.

(b) The five (5) years preceding the issuance of a teacher license, within which time academic credit must be earned, shall not include the years spent in military service.

(4) Validation of Credit from an Unapproved Institution.

(a) Credit from an unapproved institution may be accepted for licensure when such credit has been accepted in full on a transcript by an approved institution for advanced standing toward a degree, provided that not less than eight (8) semester hours of satisfactory work has been completed in the approved institution.

(b) Degree or credit from an institution accredited by a regional accrediting association but not approved for teacher education will be accepted.

(c) An applicant who holds the bachelor's degree from an unapproved institution and has otherwise met all of the requirements for a license may validate the degree and apply for a license as follows:

1. Enter an approved graduate school and complete a minimum of eight (8) semester hours in an approved educator preparation program. The applicant must successfully complete the approved educator preparation program in order to advance to a Professional License.

2. Secure a properly certified statement from an educator preparation program approved by the State Board of Education indicating all deficiencies and/or probations have been

met.

(5) Emergency Teaching Credential. A one (1) year credential, effective for only one school year, to be issued to displaced licensed teachers under one of the following circumstances:

(a) The Governor declares a state of emergency or declares a disaster under T.C.A. § 58-2-107, and the Commissioner of Education determines the necessity of conferring an emergency credential to displaced persons, or

(b) A federal state of emergency is declared anywhere in the United States, and the Commissioner of Education determines the necessity of conferring an emergency credential to displaced persons.

Authority: T.C.A. § 49-1-302.

0520-02-03-.08 Permits.

(1) Permits.

(a) The state may issue a permit when a school district or public charter school meets the following requirements:

1. A director of schools or public charter school leader must state intent to employ and indicate the position to be held by the applicant.

2. The school district or public charter school must indicate that it is unable to obtain the services of a licensed educator for the type and kind of school in which a vacancy exists.

3. The school district or public charter school must identify and document a targeted recruitment strategy for the position or shortage areas. The strategy may include, but is not limited to, partnerships with educator preparation providers, advertisements, or recruitment campaigns.

(b) The state may issue a permit to a school district or public charter school to hire an applicant one (1) time and only if the applicant holds a bachelor's degree. A bachelor's degree is not required for an applicant in occupational education.

Authority: T.C.A. § 49-1-302.

0520-02-03-.09 Denial, Formal Reprimand, Suspension and Revocation.

(1) Automatic Revocation of License. The State Board of Education shall automatically revoke the license of a licensed teacher or administrator without the right to a hearing upon receiving verification of the identity of the teacher or administrator together with a certified copy of a criminal record showing that the teacher or school administrator has been convicted of any felony or offense listed at T.C.A. §§ 40-35-501(i)(2), 39-17-417, a sexual offense or a violent sexual offense as defined in 40-39-202, any offense in title 39, chapter 13, 39-14-301 and 39-14-302, 39-14-401 and 39-14-404, 39-15-401 and 39-15-402, 39-17-1320, or any other offense in title 39, chapter 17, part 13 (including conviction on a plea of guilty or nolo contendere, conviction for the same or similar offense in any jurisdiction, or conviction for the solicitation of, attempt to commit, conspiracy, or acting as an accessory to such offenses). The Board will notify persons whose licenses are subject to automatic revocation at least thirty (30) days prior to the Board meeting at which such revocation shall occur.

(2) The State Board of Education may revoke, suspend, reprimand formally, or refuse to issue or renew a license for the following reasons:

(a) Conviction of a felony;

(b) Conviction of possession of narcotics;

(c) Being on school premises or at a school-related activity involving students while documented as being under the influence of, possessing or consuming alcohol or illegal drugs;

(d) Falsification or alteration of a license or documentation required for licensure;

(e) Denial, suspension or revocation of a license or certificate in another jurisdiction for reasons which would justify denial, suspension or revocation under this rule; or

(f) Other good cause. Other good cause shall be construed to include noncompliance with security guidelines for Tennessee Comprehensive Assessment Program (TCAP) or successor tests pursuant to T.C.A. § 49-1-607, default on a student loan pursuant to T.C.A. § 49-5-108(d)(2) or failure to report under part (e).

For purposes of this part (2), "conviction" includes entry of a plea of guilty or nolo contendere or entry of an order granting pre-trial or judicial diversion.

A person whose license has been denied, suspended or revoked may not serve as a volunteer or be employed, directly or indirectly, as an educator, paraprofessional, aide, substitute teacher or in any other position during the period of the denial, suspension or revocation.

(3) Restoration of License.

(a) A person whose license has been suspended shall have the license restored after the period of suspension has been completed, and, where applicable, the person has complied with any terms prescribed by the State Board. Suspended licenses are subject to expiration and renewal rules of the State Board.

(b) A person whose license has been denied or revoked under parts (1) or (2) may apply to the State Board to have the license issued or restored upon application showing that the cause for denial or revocation no longer exists and that the person has complied with any terms imposed in the order of denial or revocation. In the case of a felony conviction, before an application will be considered, the person must also show that any sentence imposed, including any pre-trial diversion or probationary period has been completed. Application for such issuance or restoration shall be made to the Office of Educator Licensing and shall be voted on at a regularly scheduled meeting of the State Board of Education. Nothing in this section is intended to guarantee restoration of a license.

(4) Notice of Hearing. Any person who is formally reprimanded or whose license is to be denied, suspended or revoked under part (2) or who is refused a license or certificate under part (3) shall be entitled to written notice and an opportunity for a hearing to be conducted as a contested case under the Tennessee Uniform Administrative Procedures Act, T.C.A. § 4-5-301, et seq.

(5) Notification of Office of Educator Licensing. It is the responsibility of the superintendent of the employing public or non-public school or school system to inform the Office of Educator Licensing of licensed teachers or administrators who have been suspended or dismissed, or who have resigned, following allegations of conduct which, if substantiated, would warrant consideration for license suspension or revocation under parts (1) or (2). The report shall be submitted within thirty (30) days of the suspension, dismissal or resignation. The superintendent shall also report felony convictions of licensed teachers or

administrators within thirty (30) days of receiving knowledge of the conviction.

Authority: T.C.A. § 49-1-302.

0520-02-03-.01	Licensure, General Requirements	0520-02-03-.13 through 0520-02-02-.20	Reserved
0520-02-03-.02	Licensure, Instructional Leader	0520-02-03-.21	Effective Dates
0520-02-03-.03 through 0520-02-03-.10	Reserved	0520-02-03-.22 through 0520-02-03-.94	Repealed
0520-02-03-.11	Induction		
0520-02-03-.12	Post-Baccalaureate Program		

0520-02-03-.01 LICENSURE, GENERAL REQUIREMENTS.

a. Teacher candidates seeking licensure shall complete teacher education programs approved by the State Board of Education.

b. Teacher candidates seeking licensure shall meet the requirements in at least one area of endorsement.

c. Teacher candidates seeking licensure shall complete either a full semester student teaching program or an internship program in accordance with rule 0520-02-03-.11.

d. Teachers seeking initial licensure at the graduate level may complete a post-baccalaureate program in accordance with rule 0520-02-03-.12.

e. All programs of teacher education, both undergraduate and graduate, and the institutions providing these programs must be approved by the State Board of Education. This shall be done according to standards and guidelines established by the State Board of Education and the National Council for Accreditation of Teacher Education.

f. Teacher candidates seeking initial licensure must be recommended by an institution of higher education with an approved program of teacher education; the institution shall indicate the area(s) of endorsement for which the teacher has successfully completed requirements.

g. Teacher candidates seeking initial licensure must meet all requirements for tests specified by the State Board of Education.

h. The teacher license is the principal license authorized by the State Board of Education. All endorsements except as otherwise specifically provided are included on this license.

i. Teacher candidates seeking to add endorsements to a teacher license may complete a teacher education program for additional endorsement. Institutions which offer programs for additional endorsements shall submit to the State Department of Education a list of specialty areas in which additional endorsements are offered. Institutions of higher education will verify completion of the appropriate course requirements to the Department of Education. Teachers who are licensed in Tennessee and who complete programs of study for additional endorsements at institutions in other states may be recommended by the out-of-state institution to the State Department of Education for additional endorsements. Teachers who hold a valid Tennessee license with a 7-12 endorsement may add a 7-12 endorsement by obtaining a passing score on all of the required, state-approved teacher licensure specialty exams and submitting application with the passing scores to the State Department of Education.

j. Candidates seeking licensure and endorsement as a school counselor shall complete a graduate degree and a program of studies approved by the State Board of Education. Candidates must be recommended by an institution of higher education with a preparation program approved according to standards and guidelines established by the State Board of Education.

k. Candidates seeking licensure and endorsement as a school social worker shall complete a program in social work either at the bachelor's or master's level; candidates shall also complete a program of studies in school social work approved by the State Board of Education. Candidates must be recommended by an institution of higher education with a preparation program approved according to standards and guidelines established by the State Board of Education.

l. Candidates seeking licensure and endorsement as a school psychologist shall complete a program of studies in school psychology at the graduate level including an academic year internship. Candidates must be recommended by an institution of higher education with a preparation program approved according to standards and guidelines established by the State Board of Education.

m. Candidates seeking licensure and endorsement as an occupational education teacher shall complete successfully a teacher education program not to exceed eighteen (18) semester hours designed to meet the knowledge and skills for teacher preparation. Candidates must be recommended by an institution of higher education with a preparation program approved according to standards and guidelines established by the State Board of Education.

n. Candidates seeking licensure and endorsement as a reading specialist shall complete advanced studies in a program approved by the State Board of Education. Candidates must be recommended by an institution of higher education with a preparation program approved according to standards and guidelines established by the State Board of Education.

o. Candidates seeking licensure and endorsement as a school speech-language pathologist shall complete a program of studies in speech-language pathology at the graduate level. Candidates shall meet the licensure standards, employment standards and examination requirements of the State Board of Education.

p. Candidates seeking licensure to serve as a school speech language teacher working under the direction of a school speech language pathologist are trained to supplement – not supplant – the services of a school speech language pathologist and must hold a minimum of a bachelors degree and:

(a) Hold a current teacher license earned through a teacher preparation program approved according to standards and guidelines established by the state board of education. And also completes an endorsement program of studies in speech-language including 100 hours of supervised clinical practice. Candidates must be recommended by an institution of higher education with a preparation program approved according to standards and guidelines established by the State Board of Education;

(b) Complete a teacher preparation program of studies for teachers of speech-language including 100 hours of supervised clinical practice. Candidates must be recommended by an institution of higher education with a preparation program approved according to standards and guidelines established by the State Board of Education. These candidates are eligible for a School Speech-Language Teacher (PreK-12) (A) license; or

(c) Complete a bachelor's level program of studies in speech-language, speech language disorders or communications disorders including 100 hours of supervised clinical practice. Candidates must be recommended by an institution of higher education with a bachelor level program and verify the candidate meets the standards and guidelines of the Tennessee Teacher Licensure Standards: Special Education, School Speech-Language Teacher (PreK-12). These candidates are eligible for a Special Education, School Speech-Language Teacher (PreK-12) (B) license. The (B) license does not entitle the holder to teach courses other than those designated as part of a speech language program in a school based setting. No other teaching endorsement may be

added to a (B) license. Other teaching credentials may only be earned through a preparation program approved according to standards and guidelines established by the State Board of Education.

q. Candidates seeking licensure and endorsement as a school audiologist shall complete a program of studies in audiology at the graduate level. Candidates shall meet the licensure standards, employment standards and examination requirements of the State Board of Education.

0520-02-03-.02 LICENSURE, INSTRUCTIONAL LEADER.

(1) On September 15, 2009, current State Board of Education approval of all administrator or supervisor preparation programs will expire.

(2) Beginning September 15, 2009, only programs initially approved or re-approved by the State Board of Education, according to the Board's Instructional Leadership Policy, will be eligible to prepare and recommend candidates for licensure as instructional leaders.

(3) Beginning September 15, 2009, the two-tiered licensure system for school administrators and supervisors [Beginning Administrator License (BAL) and Professional Administrator License (PAL)] will be replaced with the following four-tiered instructional leader licensure system, further outlined in State Board policy:

(a) Instructional Leadership License-Aspiring (ILL-A)

(b) Instructional Leadership License-Beginning (ILL-B)

(c) Instructional Leadership License-Professional (ILL-P)

(d) Instructional Leadership License-Exemplary (ILL-E)

(4) Instructional Leadership License-Aspiring (ILL-A). After September 15, 2009, a candidate admitted to a State Board approved instructional leadership program may receive an ILL-A if the following conditions are met:

(a) License terms and responsibilities are specified in the LEA-preparation program partnership agreement

(b) The candidate is recommended by the preparation program. An ILL-A is valid only while a candidate is enrolled and participating in an approved instructional leadership preparation program. The employment of an instructional leadership candidate with an ILL-A is not a guarantee of continued employment or job advancement, nor does it require an increased salary.

(5) Beginning Administrator License (BAL). A State Board program approved to recommend licensure and/or endorsement in school administration and supervision prior to September 15, 2009 may continue to recommend program graduates or candidates enrolled prior to September 15, 2009, for a BAL.

(a) Candidates who entered an administrator or supervisors preparation program prior to September 15, 2009, may complete that program or transition into an approved instructional leadership preparation program at the same institution and become eligible for an ILL-B.

(6) Effective September 15, 2009, assistant principals, teaching principals, or dual assignment

personnel with more than fifty percent (50%) of their responsibilities involved in instructional leadership must be properly licensed or be enrolled in a State Board approved instructional leadership preparation program.

(7) Instructional Leadership License-Beginning (ILL-B). After September 15, 2009, a candidate seeking licensure in instructional leadership must be recommended by a preparation program approved after September 15, 2009, as per State Board policy.

(a) The ILL-B is valid for three (3) years of continuous employment as an instructional leader.

(b) The ILL-B expires five (5) years after issuance if the candidate has not been employed as an instructional leader per State Board policy.

(8) Instructional Leadership License-Professional (ILL-P). Those who hold a PAL license issued prior to September 15, 2009, may maintain that license until July 1, 2022, at which time the ILL-P or ILL-E license will be required.

(9) After September 15, 2009, those who hold an ILL-B and have completed three (3) years of satisfactory employment as an instructional leader may receive an ILL-P if the candidate has met the requirements of the State Board of Education policy.

(a) The ILL-P is valid for five (5) years of employment as an instructional leader.

(b) The ILL-P is renewable per State Board policy.

(10) Instructional Leadership License - Exemplary (ILL-E). After September 15, 2009, those who have held an ILL-P or PAL for at least two (2) years shall be eligible for the ILL-E if they meet the licensure requirements for an ILL-E, are recommended by the director of the employing school system and are approved by the State Department of Education appointed leadership council as per State Board policy.

0520-02-03-.03 THROUGH 0520-02-03-.10 RESERVED.

0520-02-03-.11 INDUCTION.

(1) General Requirements.

Teacher candidates shall successfully complete an induction program consisting of either a full school year internship or a student teaching semester in accordance with standards and procedures established by the State Board of Education.

(2) Internship.

(a) The internship is a full school year experience following completion of a baccalaureate degree whereby teacher candidates are inducted into the teaching profession.

(b) The internship experience shall be planned jointly by the institutions of higher education in which the interns are enrolled and the local school system(s) in which the interns are placed with significant input from principals and teachers in the school system(s) and shall be approved by the State Board of Education.

(c) The internship experiences shall include classroom teaching, observation, course work, seminars, and planning and shall occur primarily in the school setting; internship experiences may occur in either public schools or other state approved schools.

(d) The interns shall spend more than half of the school year in direct teaching activities.

(e) The interns shall have regular and frequent contact with a team of mentors, both higher

education faculty and K-12 teachers, throughout the school year.

(f) K-12 teachers shall assume mentoring roles and, in cooperation with higher education faculty mentors, direct the activities of the interns in the classroom.

(g) The interns shall have direct teaching experiences with students with diverse learning needs and varied backgrounds in at least two classrooms which may be in different schools.

(h) The interns shall be supplemental to the existing staff in the schools in which they are located.

(i) The performance of interns shall be evaluated by the internship team composed of teacher mentors, higher education faculty mentors, and principals or their designees.

(j) The interns shall be evaluated by the principals or designees to determine apprentice licensure status using the approved local evaluation model and by the institution of higher education faculty mentors to award college credit.

(k) Teacher candidates who successfully complete a full school year internship experience shall have the year count as the first year of apprentice licensure; the internship shall count as one full school year (10 months) on the state pay scale. The salary or stipend paid to an intern, if any, may be less than the regular salary on the state salary schedule.

(3) Student Teaching.

(a) The student teaching experience is a planned professional semester of at least 15 weeks that includes full day teaching and observation activities as an initial step in the induction process for teacher candidates.

(b) The student teaching experience shall be planned jointly by the institution of higher education and the local school system with significant input from principals and teachers and shall be approved by the State Board of Education as part of the teacher education program approval process.

(c) The student teachers shall have direct teaching experiences with students with diverse learning needs and varied backgrounds in at least two classrooms which may be in different schools.

(d) Regular seminars shall be held with higher education faculty to focus on application and analysis of teaching knowledge in the classroom.

(e) Cooperating teachers shall assume mentoring roles and direct, in cooperation with higher education faculty mentors, the activities of teacher candidates in the classroom.

(f) The performance of teacher candidates shall be evaluated by cooperating teachers and supervising higher education faculty with shared responsibility for formative evaluation.

(g) Summative evaluation shall be the responsibility of the higher education faculty with significant input from and consultation with cooperating teachers.

(4) Beginning Teacher Program.

(a) The beginning teacher program is an assisted experience whereby employed first year teachers (those with less than one year experience who have completed student teaching but not an internship) are inducted into the teaching profession.

(b) The beginning teacher program shall be planned by the local school system with significant input from principals and teachers.

(c) The beginning teacher program experiences shall occur primarily in the school setting and shall include classroom observations, opportunities for informed observations of both experienced teachers and other first year teaching peers, in-service seminars, and regular and frequent contact with teacher mentors throughout the school year.

(d) Mentors, along with principals, shall provide periodic and frequent formative evaluation designed to provide feedback and support to the beginning teachers.

(e) The principal or designee shall provide summative evaluation of the beginning teacher.

(f) Assistance shall continue until the beginning teacher acquires apprentice licensure status.

0520-02-03-.12 POST-BACCALAUREATE PROGRAM.

Purpose: The post-baccalaureate teacher education program is designed to attract talented individuals and those seeking to change careers who have the potential to become good teachers.

(1) Teacher candidates may seek licensure through post-baccalaureate teacher education programs, provided such programs are approved by the State Board of Education.

(2) Institutions of higher education may apply to the State Board of Education to offer experimental post-baccalaureate teacher education programs in accordance with standards and procedures adopted by the State Board of Education.

(3) Teacher candidates admitted to post-baccalaureate teacher education programs shall be those individuals who completed baccalaureate degrees but who did not complete teacher preparation requirements.

(4) The post-baccalaureate teacher education program shall include either an internship or student teaching experience, planned jointly by the institution of higher education in which the teacher candidate is enrolled and the cooperating local school system with significant input from principals and teachers.

(5) Institutions shall require candidates to address any deficiencies in their undergraduate education to ensure the attainment of the knowledge and skills required in general education, professional education, and the major for the teaching field; additional course work may be required based upon assessment of the knowledge and skills demonstrated by the candidate when admitted to the program or through assessment of performance during the induction experience.

(6) Teacher candidates in post-baccalaureate programs shall complete at least an entire summer or full semester carrying a full load of course work in professional education including laboratory/field experiences prior to entering an induction experience.

(7) The induction experience shall be structured in accordance with the standards and guidelines of the State Board of Education for the internship or student teaching.

(8) Additional course work to meet other knowledge and skills required in general education, professional education, or the teaching area constituting a major shall be completed during and/or following the induction experience.

(9) Teacher candidates who successfully complete an internship shall have that experience count

as the first year of apprentice licensure; the internship shall count as one full school year (10 months) on the state pay scale.

(10) If candidates complete student teaching, they are eligible for beginning teacher (apprentice) licensure and for a beginning teacher program during their first year of teaching in Tennessee.

0520-02-03-.13 THROUGH 0520-02-03-.20 RESERVED.

0520-02-03-.21 EFFECTIVE DATES

(1) Teacher candidates seeking licensure and endorsement in the following areas of endorsement shall meet the requirements of Rules 0520-02-03-.01(1) through (9) and 0520-02-03-.11 by the effective dates listed below. Revised areas of endorsement are superseded according to the dates listed below.

Endorsement Area	Effective Date Sept. 1	Superseded Date Aug. 31	Single Effective Date Column
Secondary Education: Career and Technical Education			
Agriculture Education 7-12			2009
Agriscience 7-12			2009
Business Education 7-12			2004
Business Technology 7-12			2004
Family and Consumer Sciences 5-12			2008
Food Production & Management Services 9-12			2008
Early Childhood Care and Services 9-12			2008
Technology Engineering Education			2005
Marketing Education 7-12			2010
Occupational Education			
Health Sciences Education 9-12			2002
Trade and Industrial Education 9-12			2002

(2) Candidates seeking licensure and endorsement in the following areas shall meet the requirements of rules 0520-02-03-.01 (14), (15), (16), (19), and (20) by the effective dates listed below. Revised areas of endorsement are superseded according to the dates listed below.

Endorsement Area	Effective Date Sept. 1	Superseded Date Aug. 31
School Counselor PreK-12	1996	
School Social Worker PreK-12	1996	
School Psychologist PreK-12	2001	

Sp Ed School Audiologist PreK-12	2006	
Sp Ed School Speech/Language Pathologist PreK-12	2006	

(3) Candidates seeking endorsement as a beginning administrator shall meet the requirements of *rules 0520-02-03-.01 (10) through* (13) *no later than September 1, 1994.*

(4) Candidates seeking to add endorsements to a teacher license shall meet the requirements of the initial endorsements no later than the date on which the requirements for the initial endorsements become effective.

0520-02-03-.22 THROUGH 0520-02-03-.94 REPEALED

* If a roll-call vote was necessary, the vote by the Agency on these rules was as follows:

Board Member	Aye	No	Abstain	Absent	Signature (if required)
Chancey	X				
Edwards	X				
Hartgrove	X				
Johnson				X	
Pearre				X	
Roberts				X	
Rolston	X				
Tucker	X				
Troutt	X				
Student Member				X	

I certify that this is an accurate and complete copy of proposed rules, lawfully promulgated and adopted by the Tennessee State Board of Education on 9/24/2015, and is in compliance with the provisions of T.C.A. § 4-5-222. The Secretary of State is hereby instructed that, in the absence of a petition for proposed rules being filed under the conditions set out herein and in the locations described, he is to treat the proposed rules as being placed on file in his office as rules at the expiration of sixty (60) days of the first day of the month subsequent to the filing of the proposed rule with the Secretary of State.

Date: 10/7/15

Signature: [signature]

Name of Officer: Dr. Sara Heyburn

Title of Officer: Executive Director

PHYLLIS E. CHILDRESS STATE OF TENNESSEE NOTARY PUBLIC DAVIDSON COUNTY

Subscribed and sworn to before me on: 10/7/15

Notary Public Signature: [signature]

MY COMMISSION EXPIRES: January 9, 2016

My commission expires on: _____

All proposed rules provided for herein have been examined by the Attorney General and Reporter of the State of Tennessee and are approved as to legality pursuant to the provisions of the Administrative Procedures Act, Tennessee Code Annotated, Title 4, Chapter 5.

[signature]

Herbert H. Slatery III
Attorney General and Reporter

10/20/2015
Date

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Filed with the Department of State on: 10-27-15

Effective on: 1-25-16

[signature]

Tre Hargett
Secretary of State

G.O.C. STAFF RULE ABSTRACT

BOARD:	Board of Trustees of the Baccalaureate Education System Trust Fund Program
SUBJECT:	Purchase of Tuition Units
STATUTORY AUTHORITY:	Tennessee Code Annotated, Sections 49-7-805(17) and 49-7-807
EFFECTIVE DATES:	January 18, 2016 through June 30, 2016
FISCAL IMPACT:	None
STAFF RULE ABSTRACT:	Present law requires the Board to annually set the purchase price for tuition units under educational services plan tuition contracts. The price must be based on the weighted average tuition of Tennessee's four-year public universities in the academic year that begins on or after August 1 of the then current calendar year. The proposed rule specifies that, for those four-year public institutions that have differential tuition, the annual undergraduate tuition for that university used to calculate the weighted average tuition shall be the lowest tuition amount that is paid by any portion of the student population in the university in each academic year.

Regulatory Flexibility Addendum
Pursuant to T.C.A. §§ 4-5-401 through 4-5-404, prior to initiating the rule making process as described in T.C.A. § 4-5-202(a)(3) and T.C.A. § 4-5-202(a), all agencies shall conduct a review of whether a proposed rule or rule affects small businesses.

Not applicable.

Impact on Local Governments

Pursuant to T.C.A. §§ 4-5-220 and 4-5-228 "any rule proposed to be promulgated shall state in a simple declarative sentence, without additional comments on the merits of the policy of the rules or regulation, whether the rule or regulation may have a projected impact on local governments." (See Public Chapter Number 1070 (http://state.tn.us/sos/acts/106/pub/pc1070.pdf) of the 2010 Session of the General Assembly)

None.

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Sequence Number: 16-13-15
Rule ID(s): 6059
File Date: 10-20-15
Effective Date: 1-18-16

Proposed Rule(s) Filing Form

Proposed rules are submitted pursuant to Tenn. Code Ann. §§ 4-5-202, 4-5-207, and 4-5-229 in lieu of a rulemaking hearing. It is the intent of the Agency to promulgate these rules without a rulemaking hearing unless a petition requesting such hearing is filed within ninety (90) days of the filing of the proposed rule with the Secretary of State. To be effective, the petition must be filed with the Agency and be signed by twenty-five (25) persons who will be affected by the amendments, or submitted by a municipality which will be affected by the amendments, or an association of twenty-five (25) or more members, or any standing committee of the General Assembly. The agency shall forward such petition to the Secretary of State.

Pursuant to Tenn. Code Ann. § 4-5-229, any new fee or fee increase promulgated by state agency rule shall take effect on July 1, following the expiration of the ninety (90) day period as provided in § 4-5-207. This section shall not apply to rules that implement new fees or fee increases that are promulgated as emergency rules pursuant to § 4-5-208(a) and to subsequent rules that make permanent such emergency rules, as amended during the rulemaking process. In addition, this section shall not apply to state agencies that did not, during the preceding two (2) fiscal years, collect fees in an amount sufficient to pay the cost of operating the board, commission or entity in accordance with § 4-29-121(b).

Agency/Board/Commission:	Board of Trustees of the Baccalaureate Education System Trust Fund Program
Division:	
Contact Person:	LaKesha Page
Address:	502 Deaderick Street; 15th Floor Andrew Jackson Building; Nashville, Tennessee
Zip:	37243
Phone:	(615) 532-5888
Email:	LaKesha.page@tn.gov

Revision Type (check all that apply):

X Amendment
___ New
___ Repeal

Rule(s) Revised (**ALL** chapters and rules contained in filing must be listed here. If needed, copy and paste additional tables to accommodate multiple chapters. Please enter only **ONE** Rule Number/Rule Title per row)

Chapter Number	**Chapter Title**
1700-05-01	Tennessee Baccalaureate Education System Trust
Rule Number	**Rule Title**
1700-05-01-.05	Purchase of Tuition Units

Chapter Number	**Chapter Title**
Rule Number	**Rule Title**

Paragraph (1) in Rule 1700-05-01-.05 Purchase of Tuition Units is amended by deleting the paragraph in its entirety and replacing it with the following so that, as amended, it shall read:

(1) Purchase Price.

(a) The Board shall set the purchase price of a tuition unit pursuant to T.C.A. §49-7-807.

(b) For those four-year public universities that have differential tuition, the annual undergraduate tuition for that university used to calculate the weighted average tuition shall be the lowest tuition amount that is paid by any portion of the student population in the university in each academic year. Using the lowest tuition amount, the weighted average tuition shall be calculated in accordance with T.C.A. §49-7-807.

Authority: T.C.A. §49-7-805(16) and §49-7-807.

* If a roll-call vote was necessary, the vote by the Agency on these rules was as follows:

Board Member	Aye	No	Abstain	Absent	Signature (if required)
Peter Abernathy	X				
Shiri Anderson	X				
Keith Boring	X				
Steve Curry	X				
Russ Deaton	X				
Ron Maples	X				
Betty Sue McGarvey	X				
John Morgan	X				
Greg Turner	X				

I certify that this is an accurate and complete copy of proposed rules, lawfully promulgated and adopted by the Board of Trustees of the Baccalaureate Education System Trust Fund Program on 07/16/2014, and is in compliance with the provisions of T.C.A. § 4-5-222. The Secretary of State is hereby instructed that, in the absence of a petition for proposed rules being filed under the conditions set out herein and in the locations described, he is to treat the proposed rules as being placed on file in his office as rules at the expiration of ninety (90) days of the filing of the proposed rule with the Secretary of State.

Date: 6/5/15

Signature: Alison Cleaves

Name of Officer: Alison Cleaves

Title of Officer: Assistant General Counsel

TENNESSEE NOTARY PUBLIC STATE OF TENNESSEE DAVIDSON COUNTY COMM. EXPIRES FEB 01 2019

Subscribed and sworn to before me on: 6.5.15

Notary Public Signature:

My commission expires on: 11.3.15

All proposed rules provided for herein have been examined by the Attorney General and Reporter of the State of Tennessee and are approved as to legality pursuant to the provisions of the Administrative Procedures Act, Tennessee Code Annotated, Title 4, Chapter 5.

Herbert H. Slatery III

Herbert H. Slatery III
Attorney General and Reporter

7/8/2015
Date

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Filed with the Department of State on: 10-20-15

Effective on: 1-18-16

Tre Hargett
Secretary of State

G.O.C. STAFF RULE ABSTRACT

DEPARTMENT:	Treasury
SUBJECT:	Achieving a Better Life Experience Program
STATUTORY AUTHORITY:	Chapter 470 of the Public Acts of 2015 and 26 U.S.C. Section 529A
EFFECTIVE DATES:	January 6, 2016 through June 30, 2016
FISCAL IMPACT:	According to the Department, the state funds necessary to implement the rule were appropriated by the General Assembly.
STAFF RULE ABSTRACT:	This proposed rule establishes a program to implement the Achieving a Better Life Experience Act ("ABLE"), to assist eligible individuals in the tax free saving of money to meet qualified disability expenses. "Eligible individuals" include persons who are entitled to benefits based on blindness or disability under the Social Security Act, and the blindness or disability occurred before the individual reached 26 years of age, or a disability certification was filed for the individual with the U.S. Treasury Department for the individual for the taxable year. One or more persons may contribute to a beneficiary's ABLE account. Annual contributions are subject to the gift tax limit of $14,000. Contributions since establishment of the account are limited to $235,000 under federal law. The full text of the rules specify the process for requesting distributions from ABLE accounts, the maintenance of accounts, and the termination of accounts.

Regulatory Flexibility Addendum

Pursuant to T.C.A. §§ 4-5-401 through 4-5-404, prior to initiating the rule making process as described in T.C.A. § 4-5-202(a)(3) and T.C.A. § 4-5-202(a), all agencies shall conduct a review of whether a proposed rule or rule affects small businesses.

Not applicable.

Impact on Local Governments

Pursuant to T.C.A. §§ 4-5-220 and 4-5-228 "any rule proposed to be promulgated shall state in a simple declarative sentence, without additional comments on the merits of the policy of the rules or regulation, whether the rule or regulation may have a projected impact on local governments." (See Public Chapter Number 1070 (http://state.tn.us/sos/acts/106/pub/pc1070.pdf) of the 2010 Session of the General Assembly)

It is not anticipated that the proposed rules will impact local governments.

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Sequence Number: 16-9-16
Rule ID(s): 6057
File Date: 16-8-16
Effective Date: 1-Co-16

Proposed Rule(s) Filing Form

Proposed rules are submitted pursuant to Tenn. Code Ann. §§ 4-5-202, 4-5-207, and 4-5-229 in lieu of a rulemaking hearing. It is the intent of the Agency to promulgate these rules without a rulemaking hearing unless a petition requesting such hearing is filed within ninety (90) days of the filing of the proposed rule with the Secretary of State. To be effective, the petition must be filed with the Agency and be signed by twenty-five (25) persons who will be affected by the amendments, or submitted by a municipality which will be affected by the amendments, or an association of twenty-five (25) or more members, or any standing committee of the General Assembly. The agency shall forward such petition to the Secretary of State.

Pursuant to Tenn. Code Ann. § 4-5-229, any new fee or fee increase promulgated by state agency rule shall take effect on July 1, following the expiration of the ninety (90) day period as provided in § 4-5-207. This section shall not apply to rules that implement new fees or fee increases that are promulgated as emergency rules pursuant to § 4-5-208(a) and to subsequent rules that make permanent such emergency rules, as amended during the rulemaking process. In addition, this section shall not apply to state agencies that did not, during the preceding two (2) fiscal years, collect fees in an amount sufficient to pay the cost of operating the board, commission or entity in accordance with § 4-29-121(b).

Agency/Board/Commission:	Department of Treasury
Division:	Achieving a Better Life Experience
Contact Person:	John Murphy, Administrator
Address:	502 Deaderick Street, Andrew Jackson Building, 15th Fl., Nashville, Tennessee
Zip:	37243
Phone:	(615) 253-8771
Email:	John.Murphy@tn.gov

Revision Type (check all that apply):

___ Amendment
_x_ New
___ Repeal

Rule(s) Revised (**ALL** chapters and rules contained in filing must be listed here. If needed, copy and paste additional tables to accommodate multiple chapters. Please enter only **ONE** Rule Number/Rule Title per row)

Chapter Number	**Chapter Title**
1700-08	Achieving a Better Life Experience Program
Rule Number	**Rule Title**
1700-08-01-.01	Purpose
1700-08-01-.02	Definitions
1700-08-01-.03	Prohibitions
1700-08-01-.04	Eligibility and Application Requirements
1700-08-01-.05	Contributions
1700-08-01-.06	Distributions
1700-08-01-.07	Account Maintenance
1700-08-01-.08	Account Statements
1700-08-01-.09	Account and Contract Termination
1700-08-01-.10	Program Termination

Chapter 1700-08-01

Achieving a Better Life Experience Program

1700-08-01-.01 Purpose.

The purpose of these rules is to establish and implement the Achieving a Better Life Experience (ABLE) Act and to establish a qualified ABLE program as an agency and instrumentality of the state to assist an Eligible Individual in saving money to meet the Eligible Individual's Qualified Disability Expenses. The intent of the program is to encourage and assist individuals and families to save private funds for the purpose of supporting individuals with disabilities to maintain health, independence and quality of life.

Authority: Chapter 470 of the 2015 Public Acts; T.C.A. §71-4-802.

1700-08-01-.02 Definitions.

For the purposes of these rules the following definitions shall apply:

(1) "ABLE" means Achieving a Better Life Experience.

(2) "Act" means Chapter 470 of the 2015 Public Acts.

(3) "ABLE Account" means an account established by, owned by, and for the benefit of an Eligible Individual, who is also the Designated Beneficiary on the Account, and maintained under a Qualified ABLE Program for payment of the Eligible Individual's Qualified Disability Expenses, as provided in the Act.

(4) "Code" means § 529A of the Internal Revenue Code of 1986, codified in 26 U.S.C. § 529A, as amended, and all rules, regulations, notices, and interpretations released by the United States department of treasury, including the internal revenue service.

(5) "Contract" means a contract for an Eligible Individual's participation in the State's Qualified ABLE Program.

(6) "Contracting State" means a State without a Qualified ABLE Program that has entered into a contract with a State with a Qualified ABLE Program to provide residents of the Contracting State access to a Qualified ABLE Program.

(7) "Contribution" or "Contributions" means any payment directly allocated to an ABLE Account for the benefit of a Designated Beneficiary.

(8) "Contributor" means the Person or Persons contributing money to an ABLE Account.

(9) "Designated Beneficiary" means the Eligible Individual who has established and owns an ABLE Account, and for whose benefit the ABLE Account has been established.

(10) "Disability Certification" means a certification that the Eligible Individual has a medically determinable physical or mental impairment, which results in marked and severe functional limitations, and which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve (12) months, or is blind within the meaning of § 1614(a)(2) of the Social Security Act; and such blindness or disability occurred before the date on which the individual attained age twenty-six (26); and includes a copy of the Eligible Individual's diagnosis relating to the individual's relevant impairment or impairments, signed by a physician meeting the criteria of § 1861(r)(1) of the Social Security Act.

(11) "Distribution" means any payment from an ABLE Account, except for a Program-to-Program Transfer.

(12) "Eligible Individual" means an individual who is entitled to benefits based on blindness or disability under title II or XVI of the Social Security Act, and such blindness or disability occurred before the date on which the individual attained age twenty-six (26), or a Disability Certification with respect to such individual filed with the Secretary of the United States department of the treasury for such taxable year. The Eligible Individual is the ABLE Account owner and the Designated Beneficiary on the ABLE Account.

(13) "Excess Contribution" means the amount contributed to an ABLE Account during the taxable year of the Designated Beneficiary that exceeds the limit in effect under 26 U.S.C. §2503(b) for the calendar year in which the taxable year of the Designated Beneficiary begins.

(14) "Excess Aggregate Contribution" means the amount contributed to an ABLE Account during the taxable year of the Designated Beneficiary that causes the total amounts contributed since the establishment of the ABLE Account (or of an ABLE Account for the same Designated Beneficiary that was rolled into the current ABLE Account) to exceed the limit in effect under 26 U.S.C. §529(b)(6).

(15) "Legal Representative" means an individual who or entity that may neither have nor acquire any beneficial interest in an ABLE Account during the lifetime of the Designated Beneficiary, but can act on behalf of and for the benefit of a Designated Beneficiary for the purpose of establishing, maintaining, transacting, and terminating an ABLE Account. Not inconsistent with the Code, a legal representative shall include, but not be limited to, an individual or entity with a power of attorney, or parent or legal guardian.

(16) "Member of the Family" means a Designated Beneficiary's sibling, whether by blood or by adoption, which includes a brother, sister, stepbrother, stepsister, half-brother, and half-sister.

(17) "Person" means an individual, association, corporation, trust, charitable organization, or other such entity.

(18) "Program-to-Program Transfer" means the direct transfer of the entire balance of an ABLE Account into an ABLE Account of the same designated beneficiary in which the transferor ABLE Account is closed upon completion of the transfer, or of part or all of the balance to an ABLE Account of another Eligible Individual who is a Member of the Family of the former Designated Beneficiary, without any intervening Distribution or deemed Distribution to the Designated Beneficiary.

(19) "Rollover" means a Contribution to an ABLE Account of a Designated Beneficiary (or of an Eligible Individual who is a Member of the Family of the Designated Beneficiary) of all or a portion of an amount withdrawn from the Designated Beneficiary's ABLE Account, provided the Contribution is made within sixty (60) days of the date of the Distribution and, in the case of a Rollover to the Designated Beneficiary's ABLE Account, no rollover has been made to an ABLE Account of the Designated Beneficiary within the prior twelve (12) months.

(20) "Qualified ABLE Program" or "Program" means the ABLE program that is a qualified program pursuant to and in compliance with the Code, and that is created pursuant to the Act.

(21) "Qualified Disability Expenses" means any expenses related to the Eligible Individual's blindness or disability which are made for the benefit of an Eligible Individual who is the Designated Beneficiary. Qualified disability expenses include expenses for the following: education; housing; transportation; employment training and support; assistive technology and personal support services; health; prevention and wellness; financial management and administrative services; legal fees; expenses for oversight and monitoring; funeral and burial expenses; and other expenses approved pursuant to the Code.

(22) "Redemption Value" means the current cash value of an ABLE Account attributable to the sum of the principal invested, and the earnings or losses incurred thereon.

(23) "Refund" means the Redemption Value of the ABLE Account at the time the refund is made, minus any applicable fee charged by the State.

(24) "State" means the State of Tennessee.

(25) "Trustees" means state treasurer; the commissioner of finance and administration; the chair of the finance, ways and means committee of the senate; and the chair of the finance, ways and means committee of the house of representatives.

Authority: Chapter 470 of the 2015 Public Acts; T.C.A. §71-4-803, §71-4-804(b), and §71-4-805.

1700-08-01-.03 Prohibitions.

(1) No interest in the Program or a portion of the Program shall be used as security for a loan.

(2) No interest in an ABLE Account may be sold or exchanged.

Authority: Chapter 470 of the 2015 Public Acts; T.C.A. §71-4-805 and 71-4-806.

1700-08-01-.04 Eligibility and Application Requirements.

(1) Eligibility. In order for an Eligible Individual to participate in the Program as the owner of an ABLE Account, the Eligible Individual shall meet the following eligibility requirements by providing the following to the State:

(a) Proof that the Eligible Individual is a resident of the State or of a Contracting State as of the date of application to participate in the Program;

(b) Proof that he or she meets the definition of an Eligible Individual by providing:
1. a completed and signed certification, affidavit, attestation, verification or declaration indicating that he or she is an Eligible Individual;
2. a completed and signed authorization allowing the State to verify his or her status as an Eligible Individual; or
3. documentation indicating that he or she is an Eligible Individual.

(c) A completed and signed application on a form prescribed by the State; and

(d) Any other documentation or information required by the Code.

(2) Application. The Eligible Individual shall provide the following to accompany his or her completed and signed application to participate in the Program:

(a) A completed and signed Contract between the State and the Eligible Individual for participation in the State's Qualified ABLE Program;

(b) Proof that the Eligible Individual has a Legal Representative who has the authority to administer the Eligible Individual's ABLE Account for the benefit of the Eligible Individual, in the event that the Eligible Individual has a Legal Representative;

(c) A verification form signed under the penalty of perjury that the Eligible Individual has no other existing ABLE Account, other than an ABLE Account that will terminate with a Rollover or Program-to-Program Transfer into the new ABLE Account;

(d) Investment selection(s) made by the Eligible Individual or his or her Legal Representative. At least one (1) investment option must be selected. If more than one (1) investment option is chosen either the Eligible Individual or his or her Legal

Representative, then the Eligible Individual or Legal Representative must allocate the Contribution among the chosen investment options; and

(e) An initial Contribution of at least twenty-five dollars ($25.00) for each investment option chosen by the Eligible Individual or the Eligible Individual's Legal Representative.

(3) Confirmation. If all of the requirements contained in the Code, the Act and this chapter are met to open an ABLE Account, the State shall send a confirmation of acceptance to the Eligible Individual and will credit the Eligible Individual's ABLE Account with the amount of the initial Contribution made.

(4) Rejection. If an Eligible Individual fails to provide all of the information required in this rule within thirty (30) calendar days of the State's receipt of the Eligible Individual's application, the State Treasurer may reject the application and refund to the Eligible Individual or the Eligible Individual's Legal Representative all Contributions made less any applicable fees. Rejection of an application shall not preclude the Eligible Individual from enrolling in the Program in the future.

(5) Fraud. The State Treasurer may terminate an Eligible Individual's Contract if the Eligible Individual or the Eligible Individual's Legal Representative knowingly makes any false statement or falsifies or permits to be falsified any record or records of the Program. The amount of the refund to which the Designated Beneficiary is entitled shall be equal to the Redemption Value of the ABLE Account at the time the refund is made, minus any applicable fee charged by the State.

(6) Inactivity. If a period of ten (10) consecutive years passes with no Contributions having been made to the Designated Beneficiary's ABLE Account, or with no correspondence from the Designated Beneficiary or the Designated Beneficiary's Legal Representative, the State Treasurer shall report and deliver the amount of any refund payable under the Contract to the Tennessee Department of Treasury's Unclaimed Property Division pursuant to title 66, chapter 29, part 1. Prior to delivering the refund, the State Treasurer shall make reasonable efforts to locate the Designated Beneficiary or the Designated Beneficiary's Legal Representative. The refund shall be equal to the Redemption Value of the ABLE Account at the time the refund is delivered, minus any applicable fee charged by the State. Upon payment of the refund to the State Treasurer, the State's obligations under the Contract shall cease.

(7) Fees. The State Treasurer may charge fees to the Designated Beneficiary or collect fees from each ABLE Account for the administration of the Program or for transactions under the State's Qualified ABLE Program.

(8) Separate Accounting. The State shall maintain a separate individual ABLE Account for each Contract, showing the name of the Designated Beneficiary and the Redemption Value of the ABLE Account, including any Distributions made from the ABLE Account.

Authority: Chapter 470 of the 2015 Public Acts; T.C.A. §71-4-804(b), §71-4-805, §71-4-806, and §71-4-807.

1700-08-01-.05 Contributions.

(1) Who May Make Contributions. One (1) or more Persons may make Contributions for a taxable year into an ABLE Account for the benefit for a Designated Beneficiary who is also an Eligible Individual during that taxable year. The Designated Beneficiary shall be an Eligible Individual at the time the ABLE Account is established, at the time of any Contribution to the ABLE Account, and at the time of a Distribution from the ABLE Account for Qualified Disability Expenses. All Contributions made to a Designated Beneficiary's ABLE Account are pooled and are subject to the terms and conditions of the Designated Beneficiary's Contract.

(2) How Contributions May be Made. All Contributions to an ABLE Account shall be made only in cash and not in property, except for Program-to-Program Transfers. For the purposes of these rules, "cash" means United States dollars in the form of negotiable checks. Cash contributions may be made in the form of a check, money order, credit card, electronic transfer or similar methods acceptable to the State, but shall not include travelers' checks, cashier checks, starter

checks and credit card convenience checks. Contributions may also be made through a Rollover or through a Program-to-Program Transfer.

(3) Limit on Amount of Contributions.

(a) Contributions made to a Designated Beneficiary's ABLE Account shall not exceed the federal gift limitation contained in annual federal gift tax exclusion pursuant to 26 U.S.C. §2503(b); Contributions made in excess of this limit are referenced as "Excess Contributions". The State shall return the Excess Contributions to the Contributor, including all net income attributable to that Excess Contribution. The State shall return the Excess Contribution to the Contributor on a last-in-first-out basis until the entire Excess Contribution, along with all net income attributable to the Excess Contribution has been returned. The State shall ensure that the returned Excess Contributions are received by the Contributor on or before the due date, including extensions, for the Designated Beneficiary's federal income tax return for the taxable year in which the Excess Contribution was made. If an Excess Contribution and the net income attributable to the Excess Contribution are returned to a Contributor other than the Designated Beneficiary, the State shall notify the Designated Beneficiary of the Excess Contribution return at the same time the Excess Contribution is returned to the Contributor. For the purpose of the Contribution limitation contained in this subparagraph (a), Contributions do not include Rollovers or Program-to-Program Transfers.

(b) Contributions made to a Designated Beneficiary's ABLE Account contributed since the establishment of the ABLE Account shall not exceed the limitation in effect under 26 U.S.C. §529(b)(6). The Contributions toward the limitation shall include Contributions to any prior ABLE Account maintained by any State or its agency or instrumentality for the same Designated Beneficiary or any prior Designated Beneficiary. The State shall not accept any Excess Aggregate Contributions, and shall return all Excess Aggregate Contributions to the Contributor on a last-in-first-out basis until the entire Excess Aggregate Contribution, along with the net income attributable to the Excess Aggregate Contribution has been returned. The State shall ensure that the returned Excess Aggregate Contributions are received by the Contributor on or before the due date, including, extensions, for the Designated Beneficiary's federal income tax return for the taxable year in which the Excess Aggregate Contribution was made. If an Excess Aggregate Contribution and the net income attributable to the Excess Aggregate Contribution are returned to a Contributor other than the Designated Beneficiary, the State shall notify the Designated Beneficiary of the Excess Aggregate Contribution return at the same time the Excess Aggregate Contribution is returned to the Contributor.

Authority: Chapter 470 of the 2015 Public Acts; T.C.A. §71-4-804(b), §71-4-805, §71-4-806, and §71-4-807.

1700-08-01-.06 Distributions.

(1) Written Request. Any Distribution requests shall be made in writing by the Designated Beneficiary or the Designated Beneficiary's Legal Representative (requestor). Funds shall not be distributed from an ABLE Account until the tenth (10^{th}) day following the State's receipt of the respective funds. The distributed funds will be sent to the requestor unless the Designated Beneficiary or the Designated Beneficiary's Legal Representative request that payment be sent directly to a third party for payment.

(2) Amount and Timing of Distributions. The Distribution amount will be equal to the amount requested, not to exceed the Redemption Value of the Beneficiary's ABLE Account at the time the Distribution is processed. The Distribution amount will be paid within a maximum of sixty (60) calendar days after the State's receipt of a written Distribution request.

(3) Types of Distributions.

(a) Distributions for Qualified Disability Expenses. The Designated Beneficiary or the Designated Beneficiary's Legal Representative may direct a Distribution and payment to

the Designated Beneficiary, the Designated Beneficiary's Legal Representative or a third party as payment for a Qualified Disability Expense. The Designated Beneficiary or the Designated Beneficiary's Legal Representative shall provide the documentation requested by the State to substantiate that the Distribution will be used for the payment of Qualified Disability Expenses.

(b) Distributions for Non-Qualified Disability Expenses. The Designated Beneficiary or the Designated Beneficiary's Legal Representative may direct a Distribution and payment to a the Designated Beneficiary or the Designated Beneficiary's Legal Representative provided that the funds have been on deposit in the ABLE Account for at least ten (10) calendar days and provided that there is at least one hundred dollars ($100.00) in the ABLE Account once the Distribution is made. The earnings portion of the Distribution made for non-Qualified Disability Expenses may be subject to federal taxation as prescribed under the Code.

(c) Death of a Designated Beneficiary. In the event of a Designated Beneficiary's death, the State shall make any outstanding payments for Qualified Disability Expenses. Subject to the outstanding payments and to the extent permitted by the Code:

(i) the funds remaining in an ABLE Account not in excess of the amount equal to the total medical assistance paid for the Designated Beneficiary after the establishment of the ABLE Account, net of any premiums paid from the ABLE Account or paid by or on behalf of the Designated Beneficiary to a Medicaid Buy-In program under any State Medicaid plan established under title XIX of the Social Security Act, shall be distributed to such State upon filing a claim for payment by such State; and

(ii) the Designated Beneficiary's Legal Representative, estate administrator, estate executor or next of kin may request a Distribution of any remaining moneys in the Designated Beneficiary's ABLE Account remaining after outstanding payments for Qualified Disability Expenses and payments pursuant to subdivision (i) in this paragraph, or may request an Account and Contract termination. In the event that a Person does not request a Distribution of the remaining funds or request an Account or Contract termination, then the remaining funds shall be payable to the Tennessee Department of Treasury's Unclaimed Property Division pursuant to title 66, chapter 29, part 1.

(d) Rollovers. Any Designated Beneficiary or Designated Beneficiary's Legal Representative may request a Rollover. Any Rollover made pursuant to this rule shall be administered in accordance with the applicable Rollover provisions contained in the Code. Any Rollover made pursuant to this rule shall not exceed the Redemption Value of the Designated Beneficiary's ABLE Account minus any applicable fees charged by the State. The Redemption Value of the ABLE Account shall be determined as of the date that the Rollover is made. The portion of the Rollover amount that constituted an investment into an ABLE Account from which the Distribution was made, shall be added to the investment portion in the recipient ABLE Account, and the earnings from the ABLE Account from which the Distribution was made shall be added the into the earnings of the recipient ABLE Account.

(e) Program-to-Program Transfers. Any Designated Beneficiary or Designated Beneficiary's Legal Representative may request a Program-to-Program Transfer. The portion of the Program-to-Program Transfer amount that constituted an investment into an ABLE Account from which the Distribution was made, shall be added to the investment portion in the recipient ABLE Account, and the earnings from the ABLE Account from which the Distribution was made shall be added the into the earnings of the recipient ABLE Account.

Authority: Chapter 470 of the 2015 Public Acts; T.C.A. §71-4-804(b), §71-4-805, §71-4-806, and §71-4-807.

1700-08-01-.07 Account Maintenance.

(1) Update ABLE Account Information. Any Designated Beneficiary or Designated Beneficiary's Legal Representative may make changes and updates to the ABLE Account information as needed. These changes include updates to the following, including, but not limited to, addresses; legal name changes; phone numbers; email addresses and changes in the Designated Beneficiary's Legal Representative. The requested changes shall be provided in writing to the State.

(2) ABLE Account Limitations.

(a) Except in the case of Rollovers or Program-to-Program Transfers, a Designated Beneficiary is limited to one (1) ABLE Account at a time, regardless of where the account is located. Except in the case of Rollovers and Program-to-Program Transfers, if an ABLE Account is established for a Designated Beneficiary who already has an ABLE Account in existence, the State shall not treat the additional account as an ABLE Account; however, as long as the State returns all Contributions (including all net income attributable to the Contribution) to the Person or Persons who/that made the Contribution, then the additional account will be treated as never having been established.

(b) The funds (contributions, earnings and funds distributed for housing expenses as defined by the Social Security Administration) in a Designated Beneficiary's ABLE Account at any one time shall not exceed one hundred thousand dollars ($100,000.00) should the Designated Beneficiary participate in the Supplement Security Income program under title XVI of the Social Security Act.

(3) Change in Designated Beneficiary. A Designated Beneficiary may be changed on an ABLE Account and the transferred moneys will not be treated as a Distribution subject to federal taxation as long as the new Designated Beneficiary is an Eligible Individual within the taxable year that the change occurs and the new Designated Beneficiary is a Member of the Family of the former Designated Beneficiary. A change in the Designated Beneficiary of an ABLE Account shall only occur during the life of the Designated Beneficiary, and at the time of the change, the successor Designated Beneficiary must be an Eligible Individual.

(4) Eligible Individual Recertification. At the request of the State, each Designated Beneficiary shall recertify to the State that he or she meets the definition of an Eligible Individual. Each Designated Beneficiary or Designated Beneficiary's Legal Representative shall promptly report any changes in the Designated Beneficiary's status as an Eligible Individual. Should a Designated Beneficiary no longer meet the definition of an Eligible Individual at any time during which the Designated Beneficiary has an ABLE Account, the Designated Beneficiary shall maintain his or her status as an Eligible Individual until the end of the taxable year in which the change in the Designated Beneficiary's condition occurred. On the first day of the subsequent taxable year in which the Designated Beneficiary does not meet the definition of an Eligible Individual, the State shall not accept additional contributions into the ABLE Account and the existing money in the ABLE Account shall not be used for qualified disability expenses. Should a Designated Beneficiary subsequently meet the definition of an Eligible Individual, the State shall accept contributions into the Designated Beneficiary's ABLE Account and the existing funds in the ABLE Account can be used to pay for qualified disability expenses.

(5) Investment Direction. Any Designated Beneficiary or Designated Beneficiary's Legal Representative may, directly or indirectly, direct the investment of any Contributions to the Program, or any earning thereon, no more than two (2) times in any calendar year.

Authority: Chapter 470 of the 2015 Public Acts; T.C.A. §71-4-804(b), §71-4-805, §71-4-806, and §71-4-807.

1700-08-01-.08 Account Statements.

(1) The State shall provide Designated Beneficiaries participating in the State's Qualified ABLE

Program or the Designated Beneficiary's Legal Representative with periodic ABLE Account statements that include, but are not limited to the following: Contribution amounts; Distribution amounts; investments in the ABLE Account; total ABLE Account balance; and Redemption Value of the ABLE Account. The State shall also provide this information at the request of the Designated Beneficiary or the Designated Beneficiary's Legal Representative.

Authority: Chapter 470 of the 2015 Public Acts; T.C.A. §71-4-804(b), §71-4-805, §71-4-806, and §71-4-807.

1700-08-01-.09 Account and Contract Termination.

(1) A Designated Beneficiary may terminate his or her ABLE Account and Contract or a Designated Beneficiary's Legal Representative may terminate a Designated Beneficiary's ABLE Account and Contract at any time and for any reason upon a written request submitted to the State. In response to a written request for termination, a Refund will be paid to the Designated Beneficiary, Designated Beneficiary's Legal Representative or any other Person designated to receive a Refund under the Contract. The actual termination of the ABLE Account and Contract will not occur until all funds in the Designated Beneficiary's ABLE Account have been refunded.

Authority: Chapter 470 of the 2015 Public Acts; T.C.A. §71-4-804(b), §71-4-805, §71-4-806, and §71-4-807.

1700-08-01-.10 Program Termination.

(1) If the Trustees determine that the State's Qualified ABLE Program is, for any reason, financially infeasible, or is not beneficial to the citizens of the State of Tennessee or the State itself, then the Trustees may suspend or terminate the Program immediately. Termination of the Program will result in a termination of all ABLE Accounts and Contracts, and generate a Refund to the Designated Beneficiary, the Designated Beneficiary's Legal Representative or any other Person designated to receive a Refund under the Contract.

(2) Notwithstanding any other provision to the contrary, Refunds and other benefits payable under a Contract shall be deemed to be due and payable only to the extent that moneys are available to the credit of the State's Qualified ABLE Program, and that the State, the Tennessee Department of Treasury, the State Treasurer or the State's Qualified ABLE Program shall not be liable for any amount in excess of such sums.

(3) Should the State's Qualified ABLE Program be terminated by the Trustees and the Program assets prove to be less than would be required to fully pay all obligations of the Program in full, the State Treasurer shall first defray all Program administrative expenses. The State Treasurer shall then reduce payments owed pursuant to a Contract, pro rata, to the degree necessary to bring the total disbursement of the State's Qualified ABLE Program within the amount of the remaining funds.

Authority: Chapter 470 of the 2015 Public Acts; T.C.A. §71-4-805, §71-4-807, and 71-4-811.

* If a roll-call vote was necessary, the vote by the Agency on these rules was as follows:

Board Member	Aye	No	Abstain	Absent	Signature (if required)

I certify that this is an accurate and complete copy of proposed rules, lawfully promulgated and adopted by the State Treasurer on 08/27/2015 (*date as mm/dd/yyyy*), and is in compliance with the provisions of T.C.A. § 4-5-222. The Secretary of State is hereby instructed that, in the absence of a petition for proposed rules being filed under the conditions set out herein and in the locations described, he is to treat the proposed rules as being placed on file in his office as rules at the expiration of ninety (90) days of the filing of the proposed rule with the Secretary of State.

RHONDA J. MYERS STATE OF TENNESSEE NOTARY PUBLIC DAVIDSON COUNTY, TENN.

Date: August 27, 2015

Signature:

Name of Officer: David H. Lillard, Jr.

Title of Officer: State Treasurer

Subscribed and sworn to before me on: August 27, 2015

Notary Public Signature: Rhonda J. Myers

My commission expires on: 3-7-17

All proposed rules provided for herein have been examined by the Attorney General and Reporter of the State of Tennessee and are approved as to legality pursuant to the provisions of the Administrative Procedures Act, Tennessee Code Annotated, Title 4, Chapter 5.

Herbert H. Slatery III

Herbert H. Slatery III
Attorney General and Reporter

9/30/2015
Date

Department of State Use Only

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PUBLICATIONS

Filed with the Department of State on: 10-8-15

Effective on: 1-6-16

Tre Hargett

Tre Hargett
Secretary of State

G.O.C. STAFF RULE ABSTRACT

BOARD:	University of Tennessee Board of Trustees
CAMPUS:	Chattanooga
SUBJECT:	Traffic and Parking Violations, Penalties
STATUTORY AUTHORITY:	Tennessee Code Annotated, Section 49-9-209(e)
EFFECTIVE DATES:	January 12, 2016 through June 30, 2016
FISCAL IMPACT:	The Board anticipates increase in revenue from penalties of $105,540, which the Board states will be used primarily to cover unbudgeted City of Chattanooga storm water fees ($65,000-$75,000 annually), general parking operations, and maintenance.
STAFF RULE ABSTRACT:	The proposed rule increases from $20 to $25 the fine amount for the following violations: no parking permit; other parking violations; moving violations; and immobilized vehicles. The Board states that, while it anticipates additional revenue, its intent is to deter violators and to increase parking space for students, faculty and staff who purchase parking decals and park in the appropriate lots.

Regulatory Flexibility Addendum
Pursuant to T.C.A. §§ 4-5-401 through 4-5-404, prior to initiating the rule making process as described in T.C.A. § 4-5-202(a)(3) and T.C.A. § 4-5-202(a), all agencies shall conduct a review of whether a proposed rule or rule affects small businesses.

The rules are not anticipated to have an effect on small businesses.

Impact on Local Governments

Pursuant to T.C.A. §§ 4-5-220 and 4-5-228 "any rule proposed to be promulgated shall state in a simple declarative sentence, without additional comments on the merits of the policy of the rules or regulation, whether the rule or regulation may have a projected impact on local governments." (See Public Chapter Number 1070 (http://state.tn.us/sos/acts/106/pub/pc1070.pdf) of the 2010 Session of the General Assembly)

The rules are not anticipated to have an impact on local governments.

Department of State
Division of Publications
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Nashville, TN 37243
Phone: 615-741-2650
Email: publications.information@tn.gov

For Department of State Use Only

Sequence Number: 10-10-15
Rule ID(s): 6058
File Date: 10-14-2015
Effective Date: 1-12-2016

Proposed Rule(s) Filing Form

Proposed rules are submitted pursuant to Tenn. Code Ann. §§ 4-5-202, 4-5-207, and 4-5-229 in lieu of a rulemaking hearing. It is the intent of the Agency to promulgate these rules without a rulemaking hearing unless a petition requesting such hearing is filed within ninety (90) days of the filing of the proposed rule with the Secretary of State. To be effective, the petition must be filed with the Agency and be signed by twenty-five (25) persons who will be affected by the amendments, or submitted by a municipality which will be affected by the amendments, or an association of twenty-five (25) or more members, or any standing committee of the General Assembly. The agency shall forward such petition to the Secretary of State.

Pursuant to Tenn. Code Ann. § 4-5-229, any new fee or fee increase promulgated by state agency rule shall take effect on July 1, following the expiration of the ninety (90) day period as provided in § 4-5-207. This section shall not apply to rules that implement new fees or fee increases that are promulgated as emergency rules pursuant to § 4-5-208(a) and to subsequent rules that make permanent such emergency rules, as amended during the rulemaking process. In addition, this section shall not apply to state agencies that did not, during the preceding two (2) fiscal years, collect fees in an amount sufficient to pay the cost of operating the board, commission or entity in accordance with § 4-29-121(b).

Agency/Board/Commission:	University of Tennessee
Division:	
Contact Person:	Matthew Scoggins, Deputy General Counsel
Address:	719 Andy Holt Tower, 1331 Circle Park, Knoxville, TN
Zip:	37996-0170
Phone:	865-974-3245
Email:	scoggins@tennessee.edu

Revision Type (check all that apply):

x Amendment
___ New
___ Repeal

Rule(s) Revised (**ALL** chapters and rules contained in filing must be listed here. If needed, copy and paste additional tables to accommodate multiple chapters. Please enter only **ONE** Rule Number/Rule Title per row)

Chapter Number	**Chapter Title**
1720-02-03	Traffic and Parking Regulations
Rule Number	**Rule Title**
1720-02-03-.07	Penalties

RULES
OF
THE UNIVERSITY OF TENNESSEE
(CHATTANOOGA)

CHAPTER 1720-02-03
TRAFFIC AND PARKING REGULATIONS

1720-02-03-.01 INTRODUCTION.

(1) The purpose of these regulations is to facilitate the safe and orderly operation of University business and to provide parking facilities for this operation within the limits of available space.

(2) The Departments of Parking Services and Campus Law Enforcement are responsible for implementation and enforcement of these regulations.

(3) Any person operating a motor vehicle on the University campus is required to obey these regulations as a condition to parking or operating the vehicle on the campus.

(4) The responsibility for locating legal parking space rests with the operator of the motor vehicle. Lack of space will not be considered a valid excuse for violating any parking regulations.

(5) The University shall have no responsibility for loss or damage to any vehicle or its contents operated or parked on The University of Tennessee at Chattanooga Campus or on lots leased by The University of Tennessee at Chattanooga.

1720-02-03-.02 REGISTRATION OF VEHICLES.

(1) All motor vehicles, including motorcycles, parked on U.T.C. property between 7:00 a.m. and 5:00 p.m. or on lots leased by U.T.C. must have current U.T.C. decal/disks and be registered with the University.

(2) Decals/disks will be sold at registration, and after registration, at Parking Services.

(3) The decal/disk must be hung on the rear view mirror of the vehicle.

(4) Expired decals/disks should be removed (or covered) so that only the current decal/disk is displayed.

(5) Decals/disks must be renewed each Fall semester.

(a) General Parking: Decals/disks must be renewed at the beginning of each

Fall semester and will be valid until the beginning of the following Fall semester so long as the registrant remains a student or a University employee. This vehicle may be parked in any General lot.

(b) Reserved Parking: Decals/disks must be renewed at the beginning of each Fall semester and will be valid until the beginning of the following Fall semester so long as the registrant remains a student or a University employee. This vehicle may be parked in any General lot.

(6) The person to whom a vehicle is registered is responsible for the vehicle and all violation citations issued thereto. If the person operating the vehicle is other than the registrant when a violation is committed, both the operator and the registrant may be cited.

1720-02-03-.03 REPLACEMENT OF DECALS.

(1) A new decal/disk will be issued at no cost for a newly acquired vehicle which replaces a currently registered vehicle upon presentation of the original decal/disk to the cashier at Parking Services.

(2) If it is necessary for you to drive a car other than your registered vehicle, the transferable decal/disk must be placed on rearview mirror of replacement vehicle.

(3) Lost or stolen decal/disk will be replaced for $2.00 upon proof of loss. Only one replacement decal may be obtained at the $2.00 charge during the academic year. If additional replacement decals are required during the academic year the charge will be the current decal price.

1720-02-03-.04 VEHICLE OPERATION.

(1) All persons operating a vehicle on University property or in the campus area, which includes City streets running through University property, must be properly licensed operators.

(2) Pedestrians have the right-of-way at established pedestrian crossings, except where regulated by traffic control lights or police officers.

(3) Under normal conditions the maximum speed limit on campus streets in 15 MPH and 30 MPH on the City streets. However, vehicles may not be operated at any speed which is excessive for the conditions which may exist as a result of weather, traffic congestion, pedestrians, etc.

(4) Traffic control signs, devices, and directions of police officers must be obeyed.

(5) All persons operating vehicles are responsible for maintaining control of the vehicle, safe operation, and observance of traffic control signs, barriers and

devices.

(6) Operating a motor vehicle in any area other than a street or roadway intended for motor vehicle is prohibited.

(7) All accidents must be reported to the University Police immediately (755-4357). All vehicle break-ins or incidents should be reported immediately.

1720-02-03-.05 VIOLATIONS. The following examples constitute violations of these regulations:

(1) Parking Permits

(a) No current decal/disk (parking permit).

(b) Current decal/disk not visible in vehicle (not affixed to vehicle).

(c) Unauthorized possession of decal/disk.

(d) Falsification of decal registration information.

(e) Illegal use, reproduction or alteration of decal/disk and/or parking permit.

(f) Tampering with wheel-lock.

(2) Other Parking Violations/Overtime Metered Space.

(a) In no-parking or loading zones or unmarked spaces.

(b) In unauthorized area.

(c) Overtime parking in metered space. (Even vehicles with UTC decals/disks when parking metered areas.)

(d) Tampering with wheel-lock.

(e) Disability parking violation, as defined by State law (e.g., an unauthorized use of a disabled parking space, ramp, plate, or placard; parking a vehicle so that a portion of the vehicle encroaches into a disabled parking space in a manner which restricts, or reasonably could restrict, a person confined to a wheelchair from exiting or entering a vehicle properly parked within the disabled parking space).

(3) Moving

(a) Exceeding posted speed limit.

(b) Excessive speed for existing conditions.

(c) Failure to obey traffic control signal or sign.

(d) Failure to obey police officer.

(e) Operating vehicle without valid operator's license.

(f) Driving off roadway or street.

(g) Reckless driving and/or street.

(h) Failure to yield right-of-way at pedestrian crossing.

(i) Leaving scene of accident by participant.

(j) Failure to signal turn or stop.

(k) Wrong way on one-way street.

(l) Following too closely.

(m) Operating mechanically unsafe vehicle.

(n) Driving while under the influence of alcohol or narcotics.

(o) Operating vehicle causing loud, or unnecessary noise, such as loud mufflers, horns, P.A. systems, etc.

(4) Motorcycle Parking

(a) All cycles must have parking decals/disks.

(b) No motorcycle may be driven within the confines of a housing perimeter. They must be walked.

(c) Motorcycles are to traverse hard surface areas only, not grassy areas.

(d) All motor cycles are to be parked on hard surfaces, not on the grass or soil.

(e) Motor cycles are not to block stairways, sidewalks, or pedestrian access.

(f) Motorcycles should not be the occasion for the clutter and debris on the property.

(5) Impounded Vehicle/Towed Vehicle.

(a) The University may tow without advance notice those vehicles parked in a fire lane, designated disabled parking space, spaces reserved for designated vehicles or in such a manner as to impede the flow of traffic or disrupt the orderly affairs of the University.

(b) If a vehicle has unpaid parking citations the University may impound/tow the vehicle, if advance notice and opportunity to contest have been given. Windshield notices and/or other methods of notification will be used to provide the operator of the vehicle with advance notice of out intent to tow and the operator's right to a hearing.

(6) Fire Lane and Obstruction

(a) Blocking or obstructing traffic, street, sidewalk, driveway, fire hydrant, building entrance or exit, another vehicle or fire lane.

1720-02-03-.06 ENFORCEMENT.

(1) University violation citations must be answered at Parking Services within 72 hours (excluding Saturday, Sunday and holidays) after issuance, except that staff citations may be answered within 72 hours by mail or in person to Parking Services.

(2) City citations must be answered as indicated on the citation.

(3) A vehicle parked in a manner which blocks a fire zone, emergency exit, flow of traffic, designated disabled parking space, spaces reserved for designated vehicles, or otherwise poses a danger or disrupts the orderly affairs of the University may be impounded, immobilized, or towed.

(a) The owner of the above vehicle will be afforded a hearing by a University official prior to the assessment of any tow charges, fines, or penalties.

(b) If penalties are assessed after such hearing, impounded, towed or immobilized vehicles will be released upon proper identification and receipt for payment of all appropriate fines and penalties (see below).

(4) A vehicle which has accumulated $50.00 or more in traffic citations may be impounded or immobilized or towed if the owner of such vehicle has received advance notice and the opportunity to contest has been given. Windshield notices and/or methods of notification will be used to provide the operator of the vehicle with advance notice of intent to tow and the operator's right to a hearing. In the event the owner does not request a hearing or prevail at the hearing, his vehicle will be towed, wheel-locked or impounded whenever it is next found upon the University property whether parked legally or illegally.

1720-02-03-.07 PENALTIES.

(1) Violation Fines - Staff, Students and Visitors. All violation fines will be paid at Parking Services or the Bursar's Office.

(a)	No parking permit	~~$20.00~~25.00
(b)	Other parking violations	~~$20.00~~25.00
(c)	Overtime on meter	$8.00
(d)	Moving violations	~~$20.00~~25.00
(e)	Immobilized vehicles	~~$20.00~~25.00 plus other fines owed
(f)	Impounded Vehicle/Towed Vehicles	Amount of fine plus costs
(g)	Disability Parking Violation	$200.00

The fine for a disability parking violation is set by State law, Tennessee Code Annotated section 55-21-108. As of July 1, 2008, the fine was set at $200. The fine imposed under these regulations will increase or decrease automatically when increased or decreased by State law. The fine shall not be suspended or waived.

(h)	Fire Lane/Obstruction	$40.00

(2) Other Penalties - Students.

(a) Students who fail to pay violation fines or penalties will not be permitted to register for course work, to continue as a student, to receive credit, to receive a degree, or to obtain a transcript until the fines or penalties are paid.

(b) A staff member who persists in violating these regulations or fails to answer a citation will be reported to his department head and/or penalties may be collected through payroll deduction as specified in University Personnel Policies.

(c) Repeated violation of parking regulations will be grounds for towing away, impoundment or immobilization in accordance with regulations under enforcement.

(d) Students who persist in violating these regulations or commit a single violation under extreme circumstances will be referred to the Dean of Students office for disciplinary action which may lead to suspension or

dismissal from the University.

(e) Once automobile owner has accumulated $50.00 of unpaid fines, his car, if found parked upon University property or lots leased by the University, will be wheel-locked or towed in accordance with regulations under ENFORCEMENT.

(f) Any individual (student, faculty or staff) with outstanding traffic citations will not be allowed to register a vehicle, renew their parking permit or purchase a parking permit until indebtedness is cleared.

(g) In addition to the fine imposed for a disability parking violation, not more than five (5) hours of community service work may be imposed. Any community service work requirements imposed shall be to assist the disabled community by monitoring disabled parking spaces, providing assistance to disability centers or to disabled veterans, or other such purposes.

1720-02-03-.08 APPEALS.

(1) The Student Conduct Board will handle all student appeals.

(2) Student may appeal a violation citation within 10 class days of issuance by making application for appeal when answering the citation through forms furnished by the Parking Services.

(3) Students may request that their appeals be heard by the Student Conduct Board without their being present at the Board's meeting. Failure to appear without advance notice will result in the case being considered in the student's absence and the decision of the board will be binding.

(4) Staff and visitors appeal a violation citation through appropriate administrative channels.

(5) No appeals may be made through Campus Law Enforcement.

(6) Anyone failing to appeal within ten class days of issuance of citation loses the right to appeal.

1720-02-03-.09 RESTRICTIONS. University streets or grounds may not be used by any firm, corporation or person for advertising or commercial purposes.

1720-02-03-.10 SPECIAL OCCASIONS AND EMERGENCIES. On special occasions, for example: athletic events, concerts, graduation exercises, etc., and in emergencies, parking and traffic limitation may be imposed by the Departments of Parking Services and Campus Law Enforcement as required by the conditions which prevail.

1720-02-03-.11 PEDESTRIAN REGULATIONS.

(1) Students and staff members must not endanger their safety or constitute an unreasonable impediment to lawful vehicular traffic by crossing streets at other than authorized lanes or by willfully walking or congregating in the streets.

(2) All personnel are expected to avoid walking across lawns or against traffic signs.

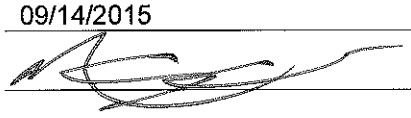
(3) Violations of these regulations will be cited through appropriate channels for disciplinary action.

* If a roll-call vote was necessary, the vote by the Agency on these rules was as follows:

Board Member	Aye	No	Abstain	Absent	Signature (if required)
Governor Bill Haslam				x	
Commissioner Julius Johnson	x				
Commissioner Candice McQueen				x	
Dr. Joe DiPietro	x				
Dr. Russ Deaton (non-voting)					
Charles C. Anderson, Jr.	x				
Jalen Blue	x				
Shannon Brown	x				
George E. Cates	x				
Dr. Brian Donavant (non-voting)					
Spruell Driver, Jr.	x				
Dr. William E. Evans				x	
John N. Foy	x				
Crawford Gallimore				x	
Dr. David Golden	x				
Vicky B. Gregg	x				
Raja J. Jubran	x				
Brad A. Lampley	x				
James L. Murphy, III	x				
Sharon J. Miller Pryse	x				
Miranda N. Rutan (non-voting)					
Rhedona Rose	x				
Julia T. Wells	x				
Charles E. Wharton	x				
Tommy G. Whittaker	x				

I certify that this is an accurate and complete copy of proposed rules, lawfully promulgated and adopted by the University of Tennessee Board of Trustees on 06/25/2015, and is in compliance with the provisions of T.C.A. § 4-5-222. The Secretary of State is hereby instructed that, in the absence of a petition for proposed rules being filed under the conditions set out herein and in the locations described, he is to treat the proposed rules as being placed on file in his office as rules at the expiration of ninety (90) days of the filing of the proposed rule with the Secretary of State.

Date: 09/14/2015

Signature: 

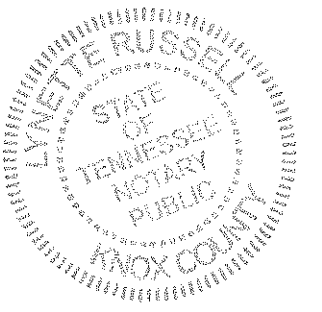
Name of Officer: Matthew Scoggins

Title of Officer: Deputy General Counsel

Subscribed and sworn to before me on: 9-14-15

Notary Public Signature: Lynette Russell

My commission expires on: 12-4-18



All proposed rules provided for herein have been examined by the Attorney General and Reporter of the State of Tennessee and are approved as to legality pursuant to the provisions of the Administrative Procedures Act, Tennessee Code Annotated, Title 4, Chapter 5.

Herbert H. Slatery III
Attorney General and Reporter

10/5/2015
Date

Department of State Use Only

Filed with the Department of State on: 10-14-15

Effective on: 1-12-16

Tre Hargett
Secretary of State

G.O.C. STAFF RULE ABSTRACT

DEPARTMENT:	Health
DIVISION:	Office of Health Planning
SUBJECT:	Hospital Corporation Act of 1993
STATUTORY AUTHORITY:	Tennessee Code Annotated, Section 68-11-1307(d)
EFFECTIVE DATES:	January 4, 2016 through June 30, 2016
FISCAL IMPACT:	None.
STAFF RULE ABSTRACT:	The rulemaking hearing rules implement changes to the Hospital Corporation Act of 1993 that were required or authorized by Chapter 464 of the Public Acts of 2015. The Act authorizes hospitals to enter into cooperative agreements for the combining of their assets for the provision of health services. Parties to a cooperative agreement may apply to the Department for a certificate of public advantage, which the Department may issue if the benefits of the cooperative agreement outweigh its disadvantages. A certificate of public advantage evidences extension of state action immunity from antitrust law to the fullest extent possible for the parties to the agreement for which the certificate was issued. The Act extends responsibility to the Department for active state supervision to protect the public interest and to assure the reduction in competition of health care and related services continues to be outweighed by clear and convincing evidence of the likely benefits of the cooperative agreement, including but not limited to improvements to population health, access to services and economic advantages to the public. A certificate of public advantage will be denied or terminated if the likely benefits of the cooperative agreement fail to outweigh any disadvantages attributable to a potential reduction in competition resulting from the

cooperative agreement by clear and convincing evidence.

Public Hearing Comments

One copy of a document containing responses to comments made at the public hearing must accompany the filing pursuant to T.C.A. § 4-5-222. Agencies shall include only their responses to public hearing comments, which can be summarized. No letters of inquiry from parties questioning the rule will be accepted. When no comments are received at the public hearing, the agency need only draft a memorandum stating such and include it with the Rulemaking Hearing Rule filing. Minutes of the meeting will not be accepted. Transcripts are not acceptable.

Hospital Cooperation Act of 1993 (COPA) Rulemaking Hearing
September 24, 2015
Public Comments

Both oral and written comments were received for this rulemaking hearing. The oral comments will be addressed first.

The first oral comments came from Tom Lee with the law firm of Frost, Brown, Todd speaking on behalf of Amerigroup as its attorney. He stated that Amerigroup presently serves 400,000 Tennesseans through its role as a managed care organization contracting with TennCare. Mr. Lee thanked the Department for the work it has put in on this process already, and introduced Bob Leibenluft, with the Hogan Louvells Law Firm who has thirty-five years of experience as a health and antitrust lawyer, as well as experience with the FTC.

Mr. Leibenluft stated that as one of the largest purchasers of health care services in Tennessee, Amerigroup depends on competition among healthcare providers to contain healthcare costs, ensure quality, promote innovation, and offer alternatives to its members. He expressed concern over the rules, stating that without any adequate substitute for competition in Tennessee, granting state action immunity would harm the hundreds of thousands of Tennesseans whose care Amerigroup coordinates. He went on to state that the granting of state action immunity is rare; just four states have considered it and one of those states, North Carolina, is considering revoking it. He stated several reasons why state action immunity is unusual. First, he said that we rely on competition within the healthcare market to incentivize hospitals to keep their costs low, not to raise prices, to keep quality high, to acquire the latest technologies, to provide convenient access, to attract the best employees, and to provide the level of amenities and services that will satisfy their customers. Secondly, he stated that it is impossible to substitute regulatory oversight for competition. Third, he said regulatory oversight must be ongoing and dynamic. Fourth, he said healthcare providers do not need to merge to achieve efficiencies. They can achieve better quality and lower costs on their own. And as the FTC has pointed out on numerous occasions, there are many ways that healthcare systems can collaborate with each other which does not raise the competitive concerns of a merger. Fifth, he said once a merger is approved under state action immunity, it is difficult to undo. Lastly, he said the law, including two very recent Supreme Court cases, sets a very high bar for private parties to obtain state action antitrust immunity. The high bar imposes very stringent requirements on the State not only to articulate clearly its intent to displace competition, but also with respect to how the legislation has been enacted to provide active and ongoing supervision over anticompetitive conduct. He went on to state that for these reasons, the regulation under consideration governing the process for seeking a COPA and the oversight that will be applied if a COPA is granted are critically important and that the Department must ensure that the COPA applicant clearly describe the following: 1) what they intend to achieve through the COPA; and 2) why these goals could not be achieved without COPA: what benefits they think will likely be achieved through the COPA, how these benefits can be measured, what the likely adverse effects of the COPA are, and what commitments the applicants are willing to make to protect consumers from these adverse effects. Mr. Leibenluft added that the hospitals can certainly talk about what they plan to do if they were to merge or if they were to combine. Once they combine they can talk about the merger in this kind of context; if they are seeking this kind of antitrust exemption they should be required to explain exactly what they're going to be doing. He also states that the process must provide for a transparent process so the public has a full opportunity to understand and provide input and that the applicants have the burden of proving by clear and convincing evidence, that is a high standard, that the advantages of a COPA outweigh the disadvantages.

He stated that Amerigroup believes the proposed regulations make considerable progress towards achieving these goals and commended the Department for the hard work in the drafting process, but stated that Amerigroup feels there are several ways the regulations can be improved. He urged that the proposed regulations not be scaled back and include requiring detailed information in the initial application, such as the creation of an advisory

group to provide input to track the performance under the COPA, and full funding by the applicants of the cost of the review of the application and any ongoing monitoring; emphasizing that review really has to be almost like a public service commission review of a utility. It has to be ongoing, involving staff, involving expertise. He urged for a plan of separation to be required that would show how competition will be restored in the event a COPA must be terminated. Amerigroup urges the inclusion of the following in the application review process: 1) information describing each proposed benefit under the COPA: why the benefit can't be achieved without anti-trust immunity, what metrics should be used in determining whether the benefit is being achieved, and what commitments, if any, the applicant is willing to make; 2) it should be explicit that the Department may impose certain conditions in a COPA including price caps; and 3) expanding the role of the advisory group. But Amerigroup thinks input from stakeholders and other experts are needed, not only to do that initial review but also to provide that ongoing supervision of the applicants if the COPA is granted. He closed by stating that Amerigroup has also submitted written comments including a redline for consideration and said he appreciated this opportunity to provide input to the Department on these very important regulations.

The next comments came from Highland Physicians (Holly McDaniel and Brant Kelch). Mr. Kelch stated that Highland Physicians is an Independent Practice Association and has been serving the same geographic area as the hospitals that may seek a COPA and, as such, the practice will be affected by these rules. He explained that the practice had over one thousand physicians with a diversity of opinions as to the statues/rules regarding the COPA program. He stated that typically monopolies are not good unless you are one, but that he believes that that this could be a good one for the community if done correctly. He closed by thanking the Department for its work and by drawing attention to the written comments of the physicians in the practice and stated that they were both impressed and encouraged by the rules and know that the Department is committed to making sure that this is going to be done right and done right initially, but to continue monitoring. He stated the practice totally supports that.

The next commenter was Jeff Merril, a family physician, with Mountain States Health Alliance. He stated that he has worked in the tri-cities for nineteen years and is the medical director of Clinical Transformation from Mountains States Medical Group, which is a specialty medical group comprised of over three hundred providers in over one hundred locations in northeast Tennessee and southwest Virginia. Additionally, he stated he serves on the new care collaborative board, which is the accountable care organization for Mountain States Medical Group, and he also serves on the TennCare Patients In Home Technical Advisory Group. He went on to state that there are many challenges facing the geographic region such as very high rates of obesity, mental illness, substance abuse, bacterial pneumonia, chronic diseases such as diabetes and heart disease, and that the region needs a new approach to address these problems in the region. He said the COPA legislation provides for a local solution to these problems, and that the merger of Mountain States Health Alliance and Wellmont Health Systems would allow this new organization to utilize more efficiently the limited resources to build an infrastructure that is needed to deliver affordable accessible population-based healthcare at the highest quality to people in our region, all of which aligns with the State of Tennessee's goals – to move from volume to value-based healthcare for the people of Tennessee. He closed by stating that the rules are important because they provide State oversight of the proposed new organization, and that he certainly welcomes and encourages that oversight. He thanked the Department for its work to develop rules that are both firm but also provide the new organization to be flexible. He stated the rules will allow the new organization to work and develop innovative solutions to the many healthcare challenges that face the region.

The next comment came from Greg Neil, Wellmont, CEO of Bristol Regional Medical Center. He stated that Bristol Regional serves Northeast Tennessee and Southwest Virginia including thousands each year. He stated that the ability for Bristol Regional to continue in its important mission to deliver superior healthcare with compassion is vital to ensuring the future of healthcare in upper east Tennessee and southwest Virginia. He further stated that he cares about the rules not only because they will provide the framework for the entities wishing to come together under a cooperative agreement, but also because they are integral to the proposed consolidation between Mountain States Health Alliance and Wellmont Health System. Our two organizations propose to come together to improve the healthcare of folks in our area. The overriding purpose of what is contemplated is to provide the absolute best care possible at the most affordable cost. He also stated that both organizations are indeed committed to open dialogue and engaging with the public; the organizations respect the spirit of transparency that's found in the legislation and have shown their commitment to that through an unprecedented number of public meetings and open dialogue. He said that the two organizations are working with East Tennessee State University through several focused community work groups to learn even more about what the communities in the region feel are important focus points for the future of healthcare and health status improvement in the area. He closed by stating the proposed merger will provide a locally governed solution to

the rapidly changing healthcare environment and that the two organizations believe a local solution is the best one for the future, and the Tennessee COPA Law provides that solution to become reality. He said he would let his written comments stand and thanked the Department personally for the opportunity to speak and especially for its hard work.

The next commenter was Lindy White, a CEO of two community hospitals in East Tennessee with Mountain States Health Alliance, one being an eighty bed acute care facility and one being an eighty-four bed psychiatric inpatient hospital. She first thanked the Department for its work on the rules, which she said were an innovative approach to look at how they might ultimately improve her region's health outcomes and access, and population health improvement, while simultaneously reducing costs and providing value for our patients. She stated that she has been in the trenches as a CEO in rural community hospitals for the last nine years and clearly understands the challenges that the region has aggressively faced. As reimbursements have declined and costs continue to increase, the supply of nurses and physicians continue to decline causing some of those costs to push forward. Hospital operators have to deliver care that is more efficient and more effective at reducing mortality and reducing hospital infections. She stated that this legislation and the proposed merger of the two healthcare systems will allow those decisions to be kept locally. They are pretty important decisions in regards to where we offer services, how our patients access those services and how we improve the preventative care that is needed in our communities as well as the quality. She further stated that those of us that live alongside our neighbors are in the best place to make this determination and that to have the opportunity to do so collectively, as two hospital systems, is truly one of the advantages of the legislation. She went on to say a second advantage of the legislation is that we can work together collaboratively to improve processes, continually improving processes and outcomes for our patients and do so extremely well. She closed by stating that she is really excited about the work that can come from this proposed merger, the ultimate outcome, and that one of the biggest beneficiaries from this could be the improvements and the access to behavioral health and mental health services in the region. She said this legislation could improve access to outpatient services and access to residential homes. She thanked the Department and legislature for their hard work and encouraged that the rules be flexible and that the systems welcomed Departmental oversight from the State's perspective because the systems truly believe that the benefits outweigh the disadvantages.

Alice Pope, the executive vice president and chief financial officer for Wellmont Health Systems, was the next commenter to speak. She stated that she has served Wellmont Health Systems for over 15 years and is a resident of East Tennessee. She also stated that current Tennessee law governing the type of proposed mergers such as the one contemplated by Wellmont Health Systems and Mountain States Health Alliance provides important State oversight capabilities as codified in many other states and affirmed by the United States Supreme Court; it is well regarded as providing the ability of states to regulate particular kinds of agreements where they will benefit the people we serve. She said that it is particularly important to note that the statute put in place provides the ability for the State to work to ensure that care remains affordable, that a broad array of healthcare choices be available to patients, and that access to that care is ensured and even expanded. She further stated that these are the goals of the proposed merger between Mountain States and Wellmont. She said the statute provides for a level of consumer protection that would not be available otherwise and provides an avenue for Mountain States and Wellmont to come together and ensure that a local solution is available for the future of healthcare in our region which is welcomed because out-of-market mergers result in increased healthcare costs and do not protect the consumer. She went on to state that people are mistakenly referring to out-of-market mergers when pointing to the high costs associated with mergers. She said that the oversight of the COPA will ensure that consumers are protected and costs are controlled. Lastly, she stated while others have shared that the expense of the COPA and additional government oversight is not necessary, that it is probably too late for that because seventy percent of the business is Medicare and Medicaid, so government oversight and regulations is something that we deal with every day, and we are accustomed to it and we do it very well. She closed by thanking the Department for its time and stated that Wellmont appreciates everything that is being done.

Dick Lodge, an attorney for Mountain States Health Alliance with Bass, Berry, and Sims, addressed the Board and stated that he would rely on his written comments as part of the record.

The next commenter was Paige Kisber with the Hospital Alliance of Tennessee who commented on the rules from a state-wide perspective. She stated that these rules are important because they will apply to a law that is critical for the future of local not-for-profit healthcare in upper East Tennessee and provide the opportunity for two organizations, Wellmont Health Systems and Mountain States Health Alliance, to come together to ensure a locally controlled and locally governed solution for that part of the state and to serve tens of thousands of Tennesseans while dedicated to affordability and access. She stated that by combining resources and leveraging

them, these two organizations can work as a new entity under the state law and under proper state supervision toward providing top quality healthcare that is accessible and affordable. This is a unique opportunity that cannot be passed up. She encouraged the Department to develop rules that provide the best regulations in a framework that is flexible enough to allow the proposed new organization to develop innovative healthcare solutions for the people in that part of the state. She closed by stating that she believes this structure, if approved, would uniquely position these hospital providers to be leaders in our state in helping our state to reach its population health policy goals which is good for the whole state and she thanked the Department for the work it is doing.

The next commenter was Tom Allen, General Counsel for Mountain States Health Alliance. He opened by stating that he appreciated the opportunity to come and speak and stated that the rules are lucid and understandable, and that he only has comments from a legal standpoint on two of the matters in the rules. First, he said is the requirement that a Plan of Separation be filed with the application for a Certificate of Public Advantage which the statute does not require be filed and that such requirement presents some very real logistical and planning difficulties for the organizations. Secondly, he said is the requirement of the submission of confidential, competitive information that would be disclosed to the public which would create some serious conflict with long standing principles of federal law and also just generally with other competitors that might be in the market. He also stated that the purpose of the proposed merger is to keep a local solution to high quality healthcare available, widely accessible, and affordable for the people of our region because thousands of Tennesseans whom are served by the hospital systems deserve locally governed and locally controlled healthcare options. He closed by stating that he additionally submitted written comments and that the State's policy in favor of supplanting competition is clearly articulated in the statute and that the regulations that provide for ample and rigorous active supervision by the State and thanked the Department for its efforts in developing flexible but firm rules that will allow for solid oversight to keep healthcare affordable and available to the highest quality possible for the residents of Northeast Tennessee and the entire state. He said it is vital to the people of our region and for the State of Tennessee to continue on this path to ensuring the proposed merger can move forward in a way that preserves local control over healthcare in upper East Tennessee.

Stephanie Wilkins, an attorney advisor in the Federal Trade's Commission Office of Policy Planning, next addressed the Department. She opened with a disclaimer stating that the oral remarks were her own based on the views of FTC staff and did not necessarily represent the views of the commission or of any individual commissioner, but that the Commission voted to authorize her to appear and voted to authorize staff to submit written comments. She stated that FTC staff has significant expertise in the evaluation of hospital mergers, including assessing whether a potential benefit for the transaction outweighs the potential and competitive harms. She stated that the benefits and disadvantages that the Tennessee Department of Health must consider are among the very factors that the FTC considers when evaluating a hospital merger. She further stated that the FTC devotes considerable resources to gather sufficient data and conduct detailed analysis to understand the likely competitive effects of hospital mergers. She said that, in their experience, mergers between close competitors and highly concentrated healthcare provider markets are more likely to result in significant consumer harm than a merger in a less concentrated market which she said is supported by numerous studies and comparable research. She said that, as a result, the potential benefits and efficiencies must be greater and more likely to be passed through to consumers to offset the likely anti-competitive harms and disadvantages, and that the FTC has consistently advocated that legislation purporting to grant anti-trust immunity is unnecessary to encourage co-competitive collaboration among healthcare providers which is likely to undermine the laudable public policy goal of improving quality, reducing costs, and improving patient access for healthcare services. Consequently, she said, the FTC urges the Department of Health to be diligent in evaluating the potential competitive effects of COPA applications. She also stated that FTC staff is willing to provide any expertise and information that it is authorized to share in connection with review of COPA applications, and that FTC Staff investigations may benefit from receiving this information and materials submitted as part of any COPA application that the Tennessee Attorney General's Office and the Tennessee Department of Health are able to share with it. She closed by urging that these concepts of permissible sharing of information and expertise between the Tennessee Department of Health, the Tennessee Attorney General's Office, and the FTC, be incorporated in the promulgated rules.

The next commenter was Bridget Baird with East Tennessee State University (ETSU). She first thanked the Department for allowing her to speak. She stated that people in the region face many healthcare challenges and that the COPA law would help address them in a very innovative way by providing for State oversight of the proposed merger between Wellmont Health Systems and Mountain States Health Alliance. She said that the rules would keep the organization local, which ETSU supports. She said ETSU believes the proposed new organization would positively impact East Tennessee State University and give it an opportunity to further

advance clinical education in the region which would allow it to be more competitive in pursuing research dollars currently flowing elsewhere nationally. She stated that the President of ETSU would also serve as a member of this new system board. She stated that both Mountain States and Wellmont have been forced to reduce residency positions in recent years and that this partnership would allow them to reverse that trend. She said the new organization would also partner with ETSU and others to strengthen the pipeline of physicians and allied health professionals, and attract research jobs and investments in our region, and that ETSU would help conduct a substantial comprehensive regional health care assessment which would address health gaps and disparities which would help change the future direction of the potential new system and establish its priorities. She closed by stating that these are all very important reasons why the rules are so critical and commended the Department on its efforts and hard work. She said that ETSU looks forward to working with this new organization to make the healthcare needs in our region the best possible for our constituents and our folks that live in the area.

The last comment came from Chris Puri with America's Health Insurance Plans. He stated that to the extent that the written comments would become part of the record that America's Health Insurance Plans would just rely on the written comments that were previously submitted.

The following chart represents the written comments.

ORGANIZATION	GENERAL DISPOSITION	SPECIFIC COMMENTS
America's Health Insurance Plan	Opposes the granting of a COPA because it is impossible to provide oversight that can fully substitute competition. Although TN has adopted a statute, concerns are relevant as the state adopts regulations and considers applications under those regulations. Cites Supreme Court cases North Carolina State Board of Dental Examiners v. FTC and FTC v Phoebe Putney Health System to support opinions.	Supreme Court has made it clear that state action immunity is disfavored and therefore available to private parties in only narrow circumstances. FTC has advised that COPAs are both unnecessary and are instead likely to lead to "increased health care costs and decreased access to health services." Respectfully suggests that the FTC guidance, the difficulty, cost, and uncertainty of obtaining state action immunity, and the record of consumer harm from anticompetitive hospital consolidation be weighed significantly in consideration of regulations and applications. Contends the best approach is to prevent anticompetitive mergers and preserve competition in TN.
Federal Trade Commission Staff	Emphasizes previous concerns regarding COPA programs and other antitrust exemptions. The FTC has consistently advocated that legislation purporting to grant antitrust immunity is unnecessary to encourage procompetitive collaborations among health care providers. Antitrust laws are consistent with public policy goals. Nevertheless, the FTC recognizes the Department must promulgate rules to implement TN's amended hospital corporation legislation.	FTC has significant expertise in evaluating proposed hospital and other health care provider mergers, including assessing whether the potential benefits of a transaction outweigh the potential anticompetitive harm. FTC devotes considerable resources to gather sufficient data and conduct detailed analyses to fully understand the likely competitive effects of all mergers. Requests the concepts of permissible sharing between the FTC, TN Attorney General, and TN Department of Health be incorporated in the promulgated rules.

Amerigroup (wholly owned subsidiary of Anthem) *Amerigroup is a provider of health insurance for individuals and groups eligible for coverage under Medicare Advantage (HMO) and Medicaid in Tennessee.*	Provides background on antitrust immunity under the state action doctrine, describes the legal test under which grants of immunity have been challenged by courts, provides recommendations regarding the state's role in actively supervising a COPA, including the process for evaluating a COPA application, obligations for applicants related to rate-setting in health plan contracts, and obligations for applicants related to quality measures. Provides an overview of Amerigroup's recommendation for how the Department should approach its obligations in assessing COPA applications and overseeing conduct subject to a COPA, and concludes with specific comments to the Proposed Regulations.	Keep letter of intent 45 day requirement. Require additional information in the Application including: 1. More specific information on the market and market dynamics. 2. A detailed description of each benefit that the applicants propose will be achieved through the Cooperative Agreement. 3. Request a description of any commitments the applicants are willing to make to address any potential adverse impacts resulting from the Cooperative Agreement. Require a description of the market and the competitive dynamics for health care services in the applicants' respective service areas. Delete the waiver provision for certain Application requirements Specify that the Department may impose certain conditions in a COPA and in particular pricing caps. Include a waiver of statute of limitations for antitrust challenges brought post-separation. Expand the role of the advisory group to provide support to the Department in performing ongoing supervision.
Wellmont Health System and Mountain State Alliance	Comments from a legal standpoint only.	A plan of separation is not required by the statute to be filed with the application for a certificate of public advantage. Requests that the plan of separation not be required with the application. If the Department deems the inclusion necessary, the rules should clarify that any plan of separation can be stated in general terms of processes and structure. The joint submission and public disclosure of competitively sensitive information required by the proposed rules conflicts with federal antitrust law and subjects the parties to potential antitrust liability. The parties respectfully request the rules be modified to address this significant federal law issue. The parties cite the Sherman Act, which prohibits anticompetitive collusion between competitors.

BlueCross BlueShield of Tennessee, Inc.		Reword 1200-38-01-.03(2) as follows: "Evaluation of the Application by the Department that..." Expand the role of the advisory group to assist in analyzing whether the issuance of a COPA should occur. Reorder sections in rules to follow the sequential order of intention of the regulations.
Highland Physicians, Inc. *Highland Physicians is a clinically integrated independent physician association using a collaborative model to provide coordinated medical care to the residents of Northeast Tennessee and Southwest Virginia.*	Wants to make certain the transaction is structured and monitored to guarantee fair and balanced competition among all providers in the affected region. If hospital competition in TN is reduced or eliminated through corporate combination of Wellmont and Mountain State, it is essential that regulations protect the community from potential adverse effects. Strongly recommend creating a regulatory environment that continues to encourage and protect competition to improve efficiency and quality care.	1200-38-01-.01 - Modify the definition of Hospital to reflect the breadth of services offered or controlled by most hospitals and medical centers. Add a new defined term entitled "Independent Physician." Expand on potential disadvantages at 1200-38-01-.02(2)(a)3 by including: closure or consolidation of programs and facilities, and the potential impact on access to services; reducing selected administrative and clinical functions and loss of jobs; narrowing of traditional payer networks leading to reduction of patient choice in choosing physicians and services; and negative impact on Independent Physicians due to the anticipated increase market concentration in physician and medical services controlled by the Applicants. Asserts 1200-38-01-.02(2)(a)9 is one of the most critical components of the entire Application. Recommends the regulatory text ask for explanations as to how the Cooperative Agreement will ensure continued competitive and independent operation for specific stakeholder groups potentially impacted by the merger. The explanation should reference specific policies, initiatives and commitments contained in the Cooperative Agreement that support the explanation for each stakeholder group- including a commitment not to use Certificates of Need requirements to oppose development of new ambulatory facilities by entities not a party to the Cooperative Agreement. Amend 1200-38-01-.02(2)(a)9 by asking Applicants to declare their intentions regarding future employment of physicians in the region. Expand 1200-38-01-.02(2)(a)12 by requiring the Parties to submit a summary of public campaign and communication efforts to maximize community awareness and participation in the educational processes. 1200-38-01-.02(2)(a)13(v) – One of the cornerstones of the application. Enhance to require the Parties to include with submission of their independent, expert opinion that the

		information provided is accurate and complete, and the potential competitive impact is through, and objective. 1200-38-01-.02(2)(a)13(v)- Require Applicants to describe how the financial advantages of Cooperative Agreement – particularly as it relates to potential bonuses associated with at-risk accountable care arrangements or performance incentives tied to specific payer contracts- are shared with their employed contracted physicians. 1200-38-01-.02(2)(a)13(vii) - Amend the clinical integration plan to include Independent Physicians and other providers in the service area. 1200-38-01-.02(2)(a)13(x) - Expand measures to include elements that reflect both the anticipated advantages and disadvantages. Amend 1200-38-01-.03 (3)(b) to include advantages and disadvantages. Amend 1200-38-01-.03 (3)(e) to include at least one independent physician on the advisory group. 1200-38-01-.04(1)- Increase the number of Department held public hearings held prior to acting on an application to two (2) in the geographic service area. 1200-38-01-.06- Increase the number and frequency of Department held public hearings after granting a COPA to annually for at least the first four (4) years, then at least biannually for the next four (4) years, after which holding a public hearing at least every three (3) years. 1200-38-01-.08(2) - Reconsider the appeals process for Intervenors aggrieved by a decision to grant or deny a COPA to ensure it is not onerous, as to discourage those with substantive objections.

The Department did not incorporate changes suggested by the comments, but adopted the rules as originally proposed. The Department may seek to amend the rules based upon the comments after the new chapter is effective.

Regulatory Flexibility Addendum
Pursuant to T.C.A. §§ 4-5-401 through 4-5-404, prior to initiating the rule making process as described in T.C.A. § 4-5-202(a)(3) and T.C.A. § 4-5-202(a), all agencies shall conduct a review of whether a proposed rule or rule affects small businesses.

REGULATORY FLEXIBILITY ANALYSIS

(1) The extent to which the rule or rules may overlap, duplicate or conflict with other federal, state and local governmental rules.

These rules do not overlap, duplicate or conflict with other federal, state and local government rules.

(2) Clarity, conciseness and lack of ambiguity in the rule or rules.

These rules are established with clarity, conciseness and lack of ambiguity.

(3) The establishment of flexible compliance and/or reporting requirements for small businesses.

These rules do not contain compliance and/or reporting requirements for small businesses.

(4) The establishment of friendly schedules or deadlines for compliance and/or reporting requirements for small businesses.

These rules do not contain compliance and/or reporting requirements for small businesses.

(5) The consolidation or simplification of compliance or reporting requirements for small businesses.

These rules do not compliance and/or reporting requirements for small businesses.

(6) The establishment of performance standards for small businesses as opposed to design or operational standards required in the proposed rule.

These rules do not establish performance, design or operational standards for small businesses.

(7) The unnecessary creation of entry barriers or other effects that stifle entrepreneurial activity, curb innovation or increase costs.

These rules do not create unnecessary barriers or other effects that stifle entrepreneurial activity, curb innovation or increase costs.

STATEMENT OF ECONOMIC IMPACT TO SMALL BUSINESSES

Name of Board, Committee or Council: Division of Health Planning, Certificate of Public Advantage (COPA)

1. **Type or types of small business and an identification and estimate of the number of small businesses subject to the proposed rule that would bear the cost of, and/or directly benefit from the proposed rule:**

   Any impact upon small businesses flows from the Hospital Cooperation Act of 1993 which authorizes the proposed rules. The Act implicitly recognizes that the hospitals are entering into a cooperative agreement to share assets and in some cases completely merge their assets. To the extent the transaction affects the market of the region served by the hospitals, there may be some effect on small businesses; however, the extent to which this may occur is unknown.

2. **Projected reporting, recordkeeping and other administrative costs required for compliance with the proposed rule, including the type of professional skills necessary for preparation of the report or record:**

   The parties to the cooperative agreement will submit an application and reports concerning all aspects of their service. These reports will require varying levels of skill, including economic experts, population health experts, executive leadership expertise, and financial reporting experts.

3. **Statement of the probable effect on impacted small businesses and consumers:**

   See answer to question 1 above.

4. **Description of any less burdensome, less intrusive or less costly alternative methods of achieving the purpose and/or objectives of the proposed rule that may exist, and to what extent, such alternative means might be less burdensome to small business:** N/A

5. **Comparison of the proposed rule with any federal or state counterparts:**

   Federal: N/A

   State: Rules are established in states with similar enabling legislation. During the drafting process, the rules were compared to rules regulating cooperative agreements in Maine, New York, Montana, and North Carolina. The rules in all states noted above aim to set forth active state supervision, as required under FTC v. Phoebe Putney Health System, Inc., 133 S. Ct. 1003.

6. **Analysis of the effect of the possible exemption of small businesses from all or any part of the requirements contained in the proposed rule.**

   N/A

Impact on Local Governments

Pursuant to T.C.A. §§ 4-5-220 and 4-5-228 "any rule proposed to be promulgated shall state in a simple declarative sentence, without additional comments on the merits of the policy of the rules or regulation, whether the rule or regulation may have a projected impact on local governments." (See Public Chapter Number 1070 (http://state.tn.us/sos/acts/106/pub/pc1070.pdf) of the 2010 Session of the General Assembly)

The proposed rule amendments should not have a financial impact on local governments.

Department of State
Division of Publications
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For Department of State Use Only

Sequence Number: 10-05-15
Rule ID(s): 6656
File Date: 10-06-15
Effective Date: 01-04-16

Rulemaking Hearing Rule(s) Filing Form

Rulemaking Hearing Rules are rules filed after and as a result of a rulemaking hearing (Tenn. Code Ann. § 4-5-205).

Pursuant to Tenn. Code Ann. § 4-5-229, any new fee or fee increase promulgated by state agency rule shall take effect on July 1, following the expiration of the ninety (90) day period as provided in § 4-5-207. This section shall not apply to rules that implement new fees or fee increases that are promulgated as emergency rules pursuant to § 4-5-208(a) and to subsequent rules that make permanent such emergency rules, as amended during the rulemaking process. In addition, this section shall not apply to state agencies that did not, during the preceding two (2) fiscal years, collect fees in an amount sufficient to pay the cost of operating the board, commission or entity in accordance with § 4-29-121(b).

Agency/Board/Commission:	Tennessee Department of Health
Division:	Office of Health Planning
Contact Person:	Malaka Watson
Address:	710 James Robertson Parkway, 5th Floor, Nashville, TN
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Email:	Malaka.Watson@tn.gov

Revision Type (check all that apply):

___ Amendment
X New
___ Repeal

Rule(s) Revised (**ALL** chapters and rules contained in filing must be listed here. If needed, copy and paste additional tables to accommodate multiple chapters. Please enter only **ONE** Rule Number/Rule Title per row)

Chapter Number	**Chapter Title**
1200-38-01	Hospital Cooperation Act of 1993
Rule Number	**Rule Title**
1200-38-01-.01	Purpose and Definitions
1200-38-01-.02	Application Process
1200-38-01-.03	Terms of Certification
1200-38-01-.04	Notice and Hearing
1200-38-01-.05	Issuance of COPA
1200-38-01-.06	Active Supervision by Terms of Certification
1200-38-01-.07	Modification/Termination
1200-38-01-.08	Hearing and Appeals

(Place substance of rules and other info here. Statutory authority must be given for each rule change. For information on formatting rules go to http://state.tn.us/sos/rules/1360/1360.htm)

Chapter 1200-38-01
Hospital Cooperation Act of 1993

New Chapter

Table of Contents

1200-38-01-.01 Purpose and Definitions.

The rules in this chapter implement the law relative to Cooperative Agreements and the granting of Certificates of Public Advantage pursuant to the Hospital Cooperation Act of 1993, T.C.A. §§ 68-11-1301 through 68-11-1309.

Pursuant to the Act, the Department is responsible for active state supervision to protect the public interest and to assure that the reduction in competition of health care and related services continues to be outweighed by clear and convincing evidence of the likely benefits of the Cooperative Agreement, including but not limited to improvements to population health, access to services and economic advantages to the public. The COPA will be denied or terminated if the likely benefits of the Cooperative Agreement fail to outweigh any disadvantages attributable to a potential reduction in competition resulting from the Cooperative Agreement by clear and convincing evidence.

(1) "Advisory Group" means the group of stakeholders from Applicants geographic service area, as specified in the Application, appointed by the Commissioner, in consultation with appropriate constituencies and government agencies, to recommend Measures to be considered for inclusion in an Index to objectively track Public Advantage of a single Cooperative Agreement.

(2) "Applicant" means the parties to a Cooperative Agreement who submit an Application to the Department in accordance with 1200-38-01.02.

(3) "Application" means the written materials submitted to the Department in accordance with 1200-38-01.02, by entities who desire to apply for a Certificate of Public Advantage.

(4) "Attorney General" means the Attorney General and Reporter for the State of Tennessee.

(5) "Certificate of Public Advantage ("COPA" or the "Certificate")" means the written approval by the Department which governs the Cooperative Agreement.

(6) "Certificate Holder" means the entity holding the Certificate of Public Advantage issued by the Department.

(7) "Commissioner" means the Commissioner of the Department of Health.

(8) "Cooperative Agreement" means an agreement among two (2) or more hospitals for the consolidation by merger or other combination of assets, offering, provision, operation, planning, funding, pricing,

contracting, utilization review or management of health services or for the sharing, allocation or referral of patients, personnel, instructional programs, support services and facilities or medical, diagnostic or laboratory facilities or procedures or other services traditionally offered by hospitals, including any parent or subsidiary at the time the transaction occurs or at any time thereafter.

(9) "Department" means the Department of Health.

(10) "Hospital" means an institution required to be licensed as a hospital pursuant to § 68-11-201, or defined as a psychiatric hospital in § 68-11-102; or any parent of a hospital, hospital subsidiary or hospital affiliate that provides medical or medically-related diagnostic and laboratory services or engages in ancillary activities supporting those services.

(11) "Index" means a set of Measures used to objectively track the progress of a Cooperative Agreement over time to ensure Public Advantage. The components of the Index may be assigned differential weightings and modified from time to time as determined by the Department.

(12) "Intervenor" means any hospital, physician, allied health professional, healthcare provider or other person furnishing goods or services to, or in competition with, hospitals, insurer, hospital service corporation, medical service corporation, hospital and medical services corporation, preferred provider organization, health maintenance organization or any employer or association that directly or indirectly provides health care benefits to its employees or members.

(13) "Measure" means some number of factors or benchmarks, which may be binary, a range or continuous factors.

(14) "Plan of Separation" means the written proposal submitted with an Application to return the parties to a Cooperative Agreement to a pre-consolidation state, which includes a plan for separation of any combined assets, offering, provision, operation, planning, funding, pricing, contracting, utilization review or management of health services or any combined sharing, allocation, or referral of patients, personnel, instructional programs, support services and facilities or medical, diagnostic or laboratory facilities or procedures or other services traditionally offered by hospitals, including any parent or subsidiary at the time the consolidation occurs or thereafter.

(15) "Population" means the entirety of the human population residing or domiciled in the geographic service area set out in the proposed Cooperative Agreement unless otherwise defined.

(16) "Public Advantage" means the likely benefits accruing from a Cooperative Agreement which outweigh, by clear and convincing evidence, the likely disadvantages attributable to a reduction in competition likely to result from the Cooperative Agreement.

Authority: T.C.A. §§ 68-11-1301 through 68-11-1309.

1200-38-01-.02 Application Process.

(1) Letter of Intent. At least forty-five (45) days prior to filing an Application, the parties to the proposed Cooperative Agreement shall file a letter of intent.

(a) Contents. A letter of intent shall contain the following:

1. A brief description of the proposed Cooperative Agreement, including the location of the entities and parties to the Cooperative Agreement;

2. A list that includes all assets, ownership interests, subsidiaries and affiliated businesses currently owned or operated, in whole or in part, by any party to the Cooperative Agreement that the parties propose to be included in the COPA or any assets, ownership interests, subsidiaries and affiliated businesses currently owned or operated, in whole or part, by any party to the Cooperative Agreement that will be divested, sold or affected as a result of the Cooperative Agreement;

3. A list of all business interests or units for which each party to the Cooperative Agreement has any ownership interest or a management contract that is not proposed to be included in the Cooperative Agreement;

4. The name, address and contact information of the parties to the proposed Cooperative Agreement including the executive officers, each party's respective board members and each party's general counsel;

5. A description of the entities' governing structure under the Cooperative Agreement;

6. The anticipated date of submission of the Application; and the anticipated effective date of the proposed Cooperative Agreement; and

7. The geographic service area and Population covered by the Cooperative Agreement.

(b) Amendment. The parties shall amend the letter of intent if material changes occur prior to submission of the parties' Application.

(c) Expiration. A letter of intent expires six (6) months after the date of receipt by the Department, if no Application was timely filed with the Department.

(d) Public Record. The Department shall post letters of intent on the Department's website until an Application is filed or until the letter of intent expires.

(2) Application.

(a) Parties seeking a COPA shall apply to the Department in writing. Parties shall submit the following information in the Application:

1. A descriptive title;

2. A table of contents;

3. An executive summary which includes:

(i) Goals for change to be achieved by the Cooperative Agreement;

(ii) Benefits and advantages to parties and the public including but not limited to:

(I) Population health;

(II) Access to health care and prevention services; and

(III) Healthcare operating costs, including avoidance of capital expenditures, reduction in operating expenditures and improvements in patient outcomes.

(iii) Description of how the Cooperative Agreement better prepares and positions the parties to address anticipated future changes in health care financing, organization and accountability initiatives; and

(iv) Potential disadvantages of the Cooperative Agreement.

4. The names of each party to the Application and the address of the principal business office of each party;

5. A verified statement signed by the Chairperson of the Board of Directors and Chief Executive Officer of each party to the Application; or, if one or more of the Applicants is an individual, signed by the individual Applicant; attesting to the accuracy and

completeness of the enclosed information;

6. A description of the prior history of dealings between the parties to the Application, including, but not limited to, their relationship as competitors and any prior joint ventures or other collaborative arrangements between the parties;

7. A detailed description of the proposed geographic service area, not limited to the boundaries of the State of Tennessee. If the proposed geographic service area differs from the service areas where the parties have conducted business over the five (5) years preceding the Application, a description of how and why the proposed geographic service area differs and why changes are proposed;

8. Identification of whether any services or products of the proposed Cooperative Agreement are currently being offered or capable of being offered by other providers or purchasers in the geographic service area described in the Application;

9. Explanation of how the Cooperative Agreement will assure continued competitive and independent operation of the services or products of entities not a party to the Cooperative Agreement;

10. A statement of whether there will be a Public Advantage or adverse impact on population health, quality, access, availability or cost of health care to patients and payers as a result of the Cooperative Agreement;

11. A statement of whether the projected levels of cost, access to health care or quality of health care could be achieved in the existing market without the granting of a COPA; and, for each of the above, an explanation of why or why not;

12. A report used for public information and education that is documented to have been disseminated prior to submission of the Application and submitted as part of the Application. The report must include the following:

    (i) A description of the proposed geographic service area, services and facilities to be included in the Cooperative Agreement;

    (ii) A description of how health services will change if the Application is accepted;

    (iii) A description of improvements in patient access to health care including prevention services for all categories of payers and advantages patients will experience across the entire service area regarding costs, availability or accessibility upon initiation of the Cooperative Agreement and/or findings from studies conducted by hospitals and other external entities, including health economists, clinical services and population health experts, that describe how proposed Cooperative Agreement plans are: effective with respect to resource allocation implications; efficient with respect to fostering cost containment, including, but not limited to, eliminating duplicate services and future plans; and equitable with respect to maintaining quality and competition in health services within the service area, assuring patient access to and choice of insurers and providers within the health care system;

    (iv) Findings from service area assessments that describe major health issues and trends, specific population health disparities and comparisons to state and other similar regional areas proposed to be addressed;

    (v) Impact on the health professions workforce including long-term employment and wage levels and recruitment and retention of health professionals; and

    (vi) A record of community stakeholder and consumer views of the proposed Cooperative Agreement collected through a public participatory process including

meetings and correspondence in which this report or its components were used.

13. A signed copy of the Cooperative Agreement, including:

(i) A description of any consideration passing to any person under the Cooperative Agreement including the amount, nature, source and recipient;

(ii) A detailed description of any merger, lease, change of control or other acquisition or change in ownership of the assets of any party to the Cooperative Agreement;

(iii) A list of all services and products and all service locations that are the subject of the Cooperative Agreement, including those not occurring within the boundaries of the State of Tennessee, and including, but not limited to, hospitals or other inpatient facilities, insurance products, physician practices, pharmacies, accountable care organizations, psychiatric facilities, nursing homes, physical therapy and rehabilitation units, home care agencies, wellness centers or services, surgical centers or services, dialysis centers or services, cancer centers or services, imaging centers or services, support services or any other product, facility or service;

(iv) A description of each party's contribution of capital, equipment, labor, services or other value to the transaction;

(v) A description of the competitive environment in the parties' geographic service area, including:

(I) Identification of all services and products likely to be affected by the Cooperative Agreement and the locations of the affected services and products;

(II) The parties' estimate of their current market shares for services and products and the projected market shares if the COPA is granted;

(III) A statement of how competition among health care providers or health care facilities will be reduced for the services and products included in the Cooperative Agreement; and

(IV) A statement regarding the requirement(s) for any Certificate(s) of Need resulting from the Cooperative Agreement.

(vi) Impact on the service area's health care industry workforce, including long-term employment and wage levels and recruitment and retention of health professionals;

(vii) Description of financial performance, including:

(I) A description and summary of all aspects of the financial performance of each party to the transaction for the preceding five (5) years including debt, bond rating and debt service and copies of external certified public accountants annual reports;

(II) A copy of the current annual budget for each party to the Cooperative Agreement and a three (3) year projected budget for all parties after the initiation of the Cooperative Agreement. The budgets must be in sufficient detail so as to determine the fiscal impact of the Cooperative Agreement on each party. The budgets must be prepared in conformity with generally accepted accounting principles (GAAP) and all assumptions used must be documented;

(III) A detailed explanation of the projected effects including expected change in volume, price and revenue as a result of the Cooperative Agreement, including;

I. Identification of all insurance contracts and payer agreements in place at the time of the Application and description of pending or anticipated changes that would require or enable the parties to amend their current insurance and payer agreements;

II. A description of how pricing for provider insurance contracts are calculated and the financial advantages accruing to insurers, insured consumers and the parties of the Cooperative Agreement if the COPA is granted including changes in percentage of risk-bearing contracts;

III. The following policies:

A. Policy that assures no restrictions to Medicare and/or Medicaid patients,

B. Policies for free or reduced fee care for uninsured and indigent,

C. Policies for bad debt write-off; and

D. Policies that assure parties to the Cooperative Agreement will maintain or exceed existing level of charitable programs and services.

(IV) Identification of existing or future business plans, reports, studies or other documents of each party that:

I. Discuss each party's projected performance in the market, business strategies, capital investment plans, competitive analyses and financial projections including any documents prepared in anticipation of the Cooperative Agreement; and

II. Identification of plans that will be altered, eliminated or combined under the Cooperative Agreement or subsequent COPA

(viii) A description of the plan to systematically integrate health care and preventive services among the parties of the Cooperative Agreement, in the proposed geographic service area, to address the following:

(I) A streamlined management structure to include a description of a single board of directors, centralized leadership and operating structure;

(II) Alignment of the care delivery decisions of the system with the interest of the community;

(III) Clinical standardization;

(IV) Alignment of cultural identities of the parties to the Cooperative Agreement; and

(V) Implementation of risk-based payment models to include risk, a schedule of risk assumption and proposed performance metrics to demonstrate movement toward risk assumption and a proposed global spending cap for hospital services.

(ix) A description of the plan, including economic metrics, that details anticipated efficiencies in operational costs and shared services to be gained through the Cooperative Agreement including:

(I) Proposed use of any cost savings to reduce prices borne by insurers and consumers;

(II) Proposed use of cost savings to fund low or no-cost services such as immunizations, mammograms, chronic disease management and drug and alcohol abuse services to achieve long-term population health improvements; and

(III) Other proposed uses of savings to benefit advancement of health and quality of care and outcomes.

(x) Proposed Measures and suggested baseline values with rationale for each Measure to be considered by the Department in development of an Index. Proposed Measures are to be used to continuously evaluate the Public Advantage of the results of actions approved in the COPA through the Cooperative Agreements under active supervision of the Department. Measures should include source and projected trajectory over each of the first five (5) years of the Cooperative Agreement and the trajectory if the COPA was not granted; Proposed Measures may include:

(I) Improvements in the service area population's health that exceed Measures of national and state improvement;

(II) Continuity in availability of services throughout the service area;

(III) Access and use of preventive and treatment health care services throughout the service area;

(IV) Operational savings projected to lower health care costs to payers and consumers; and

(V) Improvements in quality of services as defined by surveys of the Joint Commission.

14. An explanation of the reasons for the exclusion of any information set forth in section 1200-38-01-.02, the Application Process, including an explanation of why the item is not applicable to the Cooperative Agreement or to the parties;

15. A detailed description of the total cost resulting from the Cooperative Agreement, including, but not limited to, new costs for consultants, capital costs and management costs. The description should identify costs associated with the implementation of the Cooperative Agreement, including documentation of the availability of the necessary funds. The description should identify which costs are borne by each party;

16. A timetable for implementing all components of the Cooperative Agreement;

17. The Department shall require a Plan of Separation be submitted with the Application. The Plan of Separation shall be updated annually by the parties to the Cooperative Agreement. The parties shall provide an independent opinion from a qualified organization verifying the Plan of Separation can be operationally implemented without undue disruption to essential health services provided by the parties; and

18. The name, address and telephone number of the person(s) authorized to receive notices, reports and communications with respect to the Application.

(3) Additional Department Requirements.

(a) The Department may request additional information from the parties prior to deeming the Application complete or issuing a final decision. The Application shall not be deemed complete nor shall the one hundred twenty (120) day review period commence until all information is received by the Department.

(b) The Department shall notify the parties in writing when the Application is deemed complete.

(c) The parties shall submit simultaneously a copy of the Application and copies of all additional related materials to the Attorney General and to the Department. The Department is entrusted with the active and continuing oversight of all Cooperative Agreements.

(d) The Department may waive any of the requirements or timeframes that it finds, at its sole discretion, due to the nature of a particular Cooperative Agreement, are inapplicable to its analysis of the Cooperative Agreement.

(e) The Application and accompanying documents are public records pursuant to T.C.A. § 10-7-503 and are subject to public inspection in accordance with § 10-7-503, except for records which are confidential pursuant to state or federal law. The parties shall specify any portion of the Application which the parties contend is exempt from the Public Records Act. The parties shall include the specific authority for said exemption. Applicants shall submit two (2) copies of the Application. The first copy shall include all requested information. The second copy shall contain all requested information; however, the parties shall redact confidential information wherever possible. Nothing in this subsection shall limit or deny access to otherwise public information because an Application or accompanying document contains confidential information.

Authority: T.C.A. § 68-11-1303.

1200-38-01-.03 Terms of Certification. All COPAs shall be governed by terms of certification. The terms of certification shall include:

(1) Charges.

(a) Parties to a Cooperative Agreement who have applied to the Department for a COPA shall pay all charges incurred in the examination of the Application and, in the event the COPA is approved, all charges incurred for the review and ongoing supervision of the Cooperative Agreement, including all expenses of the Department, including, but not limited to, experts and examiners employed in the review and ongoing supervision of the Application and COPA.

(b) The compensation of the Department, experts and examiners designated by the Commissioner for examining the Cooperative Agreement and all records shall be fixed by the Commissioner at an amount commensurate with usual compensation for like services.

(c) The Department shall develop a formula to include charges incurred in the examination of the Application and charges incurred for review and ongoing supervision and invoice COPA Applicants and holders Department's costs at a regular interval.

(2) Evaluation by the Department that demonstrates Public Advantage in accordance with the standards set forth in these rules.

(a) Benefits to include:

1. Enhancement of the quality of Hospital and hospital-related care provided to Tennessee citizens;

2. Preservation of hospital facilities in geographical proximity to the communities traditionally served by those facilities;

3. Gains in the cost containment and cost-efficiency of services provided by the Hospitals involved;

4. Improvements in the utilization of Hospital resources and equipment;

5. Avoidance of duplication of Hospital resources;

6. Demonstration of population health improvement of the region served according to criteria set forth in the Cooperative Agreement and approved by the Department;

7. The extent to which medically underserved populations have access to and are projected to utilize the proposed services; and

8. Any other benefits that may be identified.

(b) Disadvantages to include:

1. The extent of any likely adverse impact on the ability of health maintenance organizations, preferred provider organizations, managed health care organizations or other healthcare payers to negotiate appropriate payment and service arrangements with Hospitals, physicians, allied healthcare professionals or other healthcare providers;

2. The extent of any reduction in competition among physicians, allied health professionals, other healthcare providers or other persons furnishing goods or services to, or in competition with, hospitals that is likely to result directly or indirectly from the Cooperative Agreement;

3. The extent of any likely adverse impact on (i) patients in the quality and availability of healthcare services and (ii) patients and payers in the price of healthcare services; and

4. The availability of arrangements that are less restrictive to competition and achieve the same benefits or a more favorable balance of benefits over disadvantages attributable to any reduction in competition likely to result from the Cooperative Agreement.

(3) Ongoing Supervision through the use of an Index tracking demonstration of Public Advantage.

(a) An Index will be created and used for the Department to evaluate the proposed and continuing Public Advantage of the COPA,

(b) The Index will include measures of the cognizable benefits in the following categories:

1. Population Health;

2. Access to Health Services;

3. Economic; and

4. Other Cognizable Benefits.

(c) Each category may be comprised of Measures for subcategories of the Index which shall be recommended separately by the Advisory Group and the parties to the Cooperative Agreement for the COPA. The Department retains exclusive authority to add to, modify, or to accept or reject recommendations when creating the Index.

(d) The Department shall establish a baseline score at the outset of the Index composition to allow for the future demonstration of a Public Advantage. Subsequently, established ranges for the score should demonstrate whether:

1. Advantage is clear and convincing; the COPA continues in effect,

2. Advantage is not clear and convincing; a modification to the Cooperative Agreement under the terms of certification will be necessary,

3. Advantage is not evident; COPA is terminated.

(e) Advisory Group

1. Recommendations. The Advisory Group shall recommend to the Commissioner Measures to be considered for inclusion in an Index to objectively track the Public Advantage of a Cooperative Agreement.

2. Meetings. The Advisory Group shall hold at least four (4) meetings with stakeholders to obtain community input and comment, with guidance from the Department.

(i) All meetings shall be open in accordance with T.C.A. §§ 8-44-101 through 8-44-111.

(ii) One (1) meeting shall provide for comment from internal stakeholders, such as persons employed by or agents of the parties to the Cooperative Agreement, its affiliates, contractors or vendors, staff clinicians or other persons deriving income from their activities with any of the parties to the Cooperative Agreement.

(iii) One (1) meeting shall provide for comment from external stakeholders, such as competing health care providers, non-staff clinicians, payers including self-insured employers, governmental agencies, non-governmental agencies, and other parties who derive income from health or health care services or are who are not employed or affiliated with and do not derive income from the parties to the Cooperative Agreement.

(iv) One (1) meeting shall provide for comment from other members of the community not represented in the internal or external stakeholder groups, including, current or potential patients, customers or other entities who are not affiliated, competing with or otherwise contracting with the parties to the Cooperative Agreement.

(v) The final meeting shall be open to all persons expressing an interest in the Cooperative Agreement and shall be held following the completion of the Advisory Group's recommendation of Measures to be considered for inclusion in the Index.

(vi) The Advisory Group, in consultation and with the approval of the Department, may elect to alter the number and composition of the meetings previously described.

(vii) The Department may provide guidance to the Advisory Group.

3. Completion of Duties.

(i) The Advisory Group's service shall conclude when the Department receives the Advisory Group's recommendation of Measures proposed for inclusion in the Index.

(ii) The Commissioner shall have the authority to reconvene the Advisory Group if necessary.

(4) Additional conditions of reporting and operations determined by the Department to demonstrate Public Advantage.

Authority: T.C.A. §§ 68-11-1303 and 68-11-1307.

1200-38-01-.04 Notice and Hearing.

(1) Prior to acting on an Application for a Certificate, the Department shall hold at least one (1) public hearing which will afford the right to any interested parties to express their views regarding an Application, and may gather additional feedback through other means from the community as needed.

(2) The Department shall give notice of the completed Application to interested parties by publishing a notice in the Tennessee administrative register in accordance with the Uniform Administrative Procedures Act, compiled in Tennessee Code Annotated, title 4, chapter 5. The notice shall include a brief summary of the requested action, how to access the Application and information concerning the time and place of the public hearing. The notice shall be published at least fifty (50) days prior to the date set for the public hearing.

Authority: T.C.A. § 68-11-1303.

1200-38-01-.05 Issuance and Maintenance of COPA.

(1) After consultation with and agreement from the Attorney General, the Department shall issue a Certificate for a Cooperative Agreement if it determines the Applicants have demonstrated by clear and convincing evidence that the likely benefits resulting from the Cooperative Agreement outweigh any disadvantages attributable to a reduction in competition that may result from the Cooperative Agreement.

(2) The Department shall grant or deny the Application within one hundred twenty (120) days of the date of filing of the Application. An Application shall not be deemed filed until the Application is complete. The Department shall act promptly to determine whether the Application is complete and may request additional documents or information from the Applicants necessary to make the Application complete. The Department's decision as to whether the Application should be granted or denied shall be in writing and set forth the basis for the decision. The Department shall furnish a copy of the decision to the Applicants, the Attorney General and any Intervenor. Prior to granting the COPA, the parties and Department will agree upon terms of certification and specific conditions that assure Public Advantage.

(3) The Department shall maintain on file all effective COPAs.

Authority: T.C.A. §§ 68-11-1301 and 68-11-1303.

1200-38-01-.06 Active Supervision by Terms of Certification.

(1) The Department shall maintain active supervision in accordance with the terms of certification described in 1200-38-01-.03. The Department shall not be bound by measures, indices or other conditions found outside of the COPA.

(2) Periodic Reports. The Department shall maintain active supervision in addition to requesting COPA holders to submit periodic reports to the Department in a format determined by the Department. The periodic reports shall be filed with the Department on January 1 and July 1 (or the following business day) each year. The reports should include the name, address, telephone number and other contact information for the party responsible for completing future reports who may be contacted by the Department to monitor the implementation of the Cooperative Agreement.

(3) Update Plan of Separation. The parties to the Cooperative Agreement shall update the parties' Plan of Separation annually and submit the updated Plan of Separation to the Department. The parties shall provide an independent opinion from a qualified organization which states the Plan of Separation can be operationally implemented without undue disruption to essential health services provided by the parties.

(4) Modification of Index. The Department retains the right to modify any Measure, Index or condition under the COPA at any time.

(5) The Department shall conduct a public hearing in the geographic service area where a COPA is in effect at least once every three (3) years.

(6) Departmental Review. At least annually, the Department shall review such documents necessary to determine compliance with the terms of the COPA and calculate the Index. In addition to any required documents, the parties shall provide the Department with the most recent verifiable values available for those Measures that are included in the Index (except any Measures or factors which the Department itself regularly generates, receives or holds). The Department reserves the right to request supplemental information when needed, as determined by the Department.

(7) Parties to the COPA must timely pay all applicable fees and invoices for initiation and maintenance of the COPA.

(8) The Department shall make public its determinations of compliance, and the Index score and trends.

(9) Failure to meet any of the terms of the COPA shall result in termination or modification of the COPA.

Authority: T.C.A. § 68-11-1303.

1200-38-01-.07 Modification/Termination.

(1) If the Department determines that the benefits no longer outweigh the disadvantages by clear and convincing evidence, the Department may first seek modification of the Cooperative Agreement with the consent of the parties.

(2) If modification is not obtained, the Department may terminate the COPA by written notice to the Certificate Holder and the Certificate Holder may appeal in the same manner as if the COPA were denied.

(3) The COPA shall remain in effect until such time as the Certificate Holder has submitted, the Department has approved and the Certificate Holder has completed the Plan of Separation.

(4) Voluntary Termination. The Certificate Holder shall notify the Department forty-five (45) days prior to voluntary termination of the Cooperative Agreement.

Authority: T.C.A. §§ 68-11-1303 and 68-11-1306.

1200-38-01-.08 Hearing and Appeals.

(1) Applicant or Certificate Holder. Any Applicant or Certificate Holder aggrieved by a decision of the Department denying an Application, refusing to act on an Application or terminating a Certificate is entitled to judicial review of the Department's decision by the chancery court of Davidson County, as specified in T.C.A. 68-11-1303.

(2) Intervenor. An Intervenor aggrieved by a decision of the Department to grant or deny the Application shall have the right to appeal the Department's decision, except that there shall be no stay of the Department's decision granting an Application unless the chancery court of Davidson County shall have issued a stay of the Department's decision in accordance with § 68-11-1304, which shall be accompanied by an appeal bond from the Intervenor. If the Intervenor shall appeal the Department's decision and the appeal is unsuccessful, the Intervenor shall be responsible for the costs of the appeal and attorneys' fees of the Applicants.

Authority: T.C.A. § 68-11-1303.

* If a roll-call vote was necessary, the vote by the Agency on these rulemaking hearing rules was as follows:

Board Member	Aye	No	Abstain	Absent	Signature (if required)
N/A					

I certify that this is an accurate and complete copy of rulemaking hearing rules, lawfully promulgated and adopted by the Tennessee Department of Health, Office of Health Planning (board/commission/other authority) on 09/24/2015 (mm/dd/yyyy), and is in compliance with the provisions of T.C.A. § 4-5-222.

I further certify the following:

Notice of Rulemaking Hearing filed with the Department of State on: *07/14/15 (mm/dd/yy)*

Rulemaking Hearing(s) Conducted on: (add more dates). *09/24/15 (mm/dd/yy)*

Date: Oct. 1, 2015

Signature: Malaka Watson

LUVENIA HARRISON
STATE OF TENNESSEE NOTARY PUBLIC
DAVIDSON COUNTY

Name of Officer: Malaka Watson
Assistant General Counsel

Title of Officer: Department of Health

Subscribed and sworn to before me on: Oct. 1, 2015

Notary Public Signature: Luvenia Harrison

My commission expires on: Sept. 10, 2018

All rulemaking hearing rules provided for herein have been examined by the Attorney General and Reporter of the State of Tennessee and are approved as to legality pursuant to the provisions of the Administrative Procedures Act, Tennessee Code Annotated, Title 4, Chapter 5.

Herbert H. Slatery III
Attorney General and Reporter

10/5/2015
Date

Department of State Use Only

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PUBLICATIONS

Filed with the Department of State on: 10-06-15

Effective on: 01-04-16

Tre Hargett
Secretary of State

G.O.C. STAFF RULE ABSTRACT

BOARD:	Board for Licensing Health Care Facilities
SUBJECTS:	Traumatic Brain Injury Residential Homes, Fees
STATUTORY AUTHORITY:	Tennessee Code Annotated, Sections 68-11-203(b)(1)(E), 68-11-206(a)(2)(E), 68-11-216, 68-11-270(n), and 68-11-273
EFFECTIVE DATES:	January 26, 2016 through June 30, 2016
FISCAL IMPACT:	None
STAFF RULE ABSTRACT:	This rulemaking hearing rule establishes the rules for traumatic brain injury residential homes as required by Chapter 1086 of the Public Acts of 2012. The rule addresses various administrative subjects, such as licensure and renewal; regulatory standards; administration, services provided; admissions, discharges, and transfers; personal and health care needs; resident records; facility standards; building standards; life safety; infectious and hazardous waste; reports; resident rights; policies and procedures for health care decision making, disaster preparedness, and fees. The rule sets the annual license fee for traumatic brain injury residential homes at $1,080. Traumatic brain injury residential homes operated by the federal or state government are exempt from the license fee.

Public Hearing Comments

One copy of a document containing responses to comments made at the public hearing must accompany the filing pursuant to T.C.A. § 4-5-222. Agencies shall include only their responses to public hearing comments, which can be summarized. No letters of inquiry from parties questioning the rule will be accepted. When no comments are received at the public hearing, the agency need only draft a memorandum stating such and include it with the Rulemaking Hearing Rule filing. Minutes of the meeting will not be accepted. Transcripts are not acceptable.

These rule amendments were originally adopted by the Board for Licensing Health Care Facilities on January 23, 2014.

At this hearing, the Board received one written comment from 21st Century Living Services represented by Ben Rose. This agency was involved in the passing of 2012 Public Chapter 1086. Mr. Rose, both in his letter and speaking at the public hearing, addressed the concerns of the agency regarding self-administration of medication. These rules, as written, require a physician's order before the resident can administer their own medication. Mr. Rose, based on his knowledge and experience, does not believe that any physician will be of the opinion that residents suffering from brain injuries will be able to self-medicate.

Rose submitted that the requirement of a physician's order is contrary to the intent of the statute which he says was to create a licensure category for treatment of those suffering from brain injuries that would only require the facility to provide a staff of Certified Brain Injury Specialists.

The Board did not accept the proposed change to "self-administration of medication" because it felt that the issue had been thoroughly considered and researched. It further determined that patient safety requires a physician to be of the opinion that the patient suffering from traumatic brain injury is able to self-administer his/her medication and that the physician must complete a written order stating the same for the resident's record.

After the January rulemaking hearing, the Board held a specially scheduled meeting on March 11, 2014. At this time, the Board voted to include several additional amendments to the rules which were mandated by statute.

First, the Board voted to add the definitions for abuse, misappropriation of resident belongings, and neglect. These additional amendments were necessary to ensure that the definitions would be in conformity with the definitions contained in T.C.A. § 68-11-211 (Reporting incidents of abuse, neglect, and misappropriation). The Board also voted to replace the existing definition for "do not resuscitate order" and to add new definitions for "physician assistant" and "physician's orders for scope of treatment (POST)."

Secondly, pursuant to 2013 Public Chapter No. 254, the Board also voted to amend the current rules regarding policies and procedures for health care decision-making by deleting references to universal do not resuscitate orders and using in its stead the title, "Physician Orders for Scope of Treatment".

Lastly, the Board voted to replace the Physician's Orders for Scope of Treatment (POST) form with a new form presented to the Board that included the necessary corrections required by 2013 Public Chapter No. 254.

Regulatory Flexibility Addendum
Pursuant to T.C.A. §§ 4-5-401 through 4-5-404, prior to initiating the rule making process as described in T.C.A. § 4-5-202(a)(3) and T.C.A. § 4-5-202(a), all agencies shall conduct a review of whether a proposed rule or rule affects small businesses.

REGULATORY FLEXIBILITY ANALYSIS

(1) **The extent to which the rule or rule may overlap, duplicate, or conflict with other federal, state, and local governmental rules.**

These rules do not overlap, duplicate, or conflict with other federal, state, and local rules.

(2) **Clarity, conciseness, and lack of ambiguity in the rule or rules.**

These rules exhibit clarity, consciousness, and lack of ambiguity.

(3) **The establishment of flexible compliance and/or reporting requirements for small businesses.**

These rules do not establish flexible compliance and/or reporting requirements for small businesses.

(4) **The establishment of friendly schedules or deadlines for compliance and/or reporting requirements for small businesses.**

These rules do not establish friendly schedules or deadlines for compliance and/or reporting requirements for small businesses.

(5) **The consolidation or simplification of compliance or reporting requirements for small businesses.**

These rules do not consolidate or simplify compliance or reporting requirements for small businesses.

(6) **The establishment of performance standards for small businesses as opposed to design or operational standards required in the proposed rule.**

These rules do not establish performance standards for small businesses.

(7) **The unnecessary creation of entry barriers or other effects that stifle entrepreneurial activity, curb innovation, or increase costs.**

These rules do not stifle entrepreneurial activity, curb innovation, or increase costs.

STATEMENT OF ECONOMIC IMPACT TO SMALL BUSINESSES

Name of Board, Committee or Council: Board for Licensing Health Care Facilities

Rulemaking hearing date: N/A

1. **Type or types of small business and an identification and estimate of the number of small businesses subject to the proposed rule that would bear the cost of, and/or directly benefit from the proposed rule:**

   2012 Public Chapter 1086 creates a new licensing category for Traumatic Brain Injury Residential Homes. Those small businesses wishing to open Traumatic Brain Injury Residential Homes would benefit and bear the costs of the proposed rule.

2. **Projected reporting, recordkeeping and other administrative costs required for compliance with the proposed rule, including the type of professional skills necessary for preparation of the report or record:**

   The projected reporting, recordkeeping and other administrative costs required for compliance with the proposed rule should be minimal.

3. **Statement of the probable effect on impacted small businesses and consumers:**

   Small businesses and consumers will be positively impacted by the proposed rules as a new licensure category has been provided to create new businesses and a facility that will specifically address the needs of consumers suffering from, or consumers who are caring for someone who has suffered a traumatic brain injury.

4. **Description of any less burdensome, less intrusive or less costly alternative methods of achieving the purpose and/or objectives of the proposed rule that may exist, and to what extent, such alternative means might be less burdensome to small business:**

   There are no less burdensome, less intrusive or less costly alternative methods of achieving the purpose and or objectives of the proposed rule.

5. **Comparison of the proposed rule with any federal or state counterparts:**

   Federal: None.

   State: Many states provide licensure categories for residents with traumatic brain injuries as these injuries are specific and require certain types of care that other facilities cannot, for various reasons, provide on a continuing basis.

6. **Analysis of the effect of the possible exemption of small businesses from all or any part of the requirements contained in the proposed rule.**

   These proposed rules are required to comply with 2012 Public Chapter 1086 and as such do not provide for any exemptions for small businesses.

Impact on Local Governments

Pursuant to T.C.A. §§ 4-5-220 and 4-5-228 "any rule proposed to be promulgated shall state in a simple declarative sentence, without additional comments on the merits of the policy of the rules or regulation, whether the rule or regulation may have a projected impact on local governments." (See Public Chapter Number 1070 (http://state.tn.us/sos/acts/106/pub/pc1070.pdf) of the 2010 Session of the General Assembly)

The proposed rule amendments should not have a financial impact on local governments.

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For Department of State Use Only

Sequence Number: 10-24-15
Rule ID(s): 6065
File Date: 10-28-15
Effective Date: 1-26-16

Rulemaking Hearing Rule(s) Filing Form

Rulemaking Hearing Rules are rules filed after and as a result of a rulemaking hearing (Tenn. Code Ann. § 4-5-205).

Pursuant to Tenn. Code Ann. § 4-5-229, any new fee or fee increase promulgated by state agency rule shall take effect on July 1, following the expiration of the ninety (90) day period as provided in § 4-5-207. This section shall not apply to rules that implement new fees or fee increases that are promulgated as emergency rules pursuant to § 4-5-208(a) and to subsequent rules that make permanent such emergency rules, as amended during the rulemaking process. In addition, this section shall not apply to state agencies that did not, during the preceding two (2) fiscal years, collect fees in an amount sufficient to pay the cost of operating the board, commission or entity in accordance with § 4-29-121(b).

Agency/Board/Commission:	Department of Health
Division:	Board for Licensing Health Care Facilities
Contact Person:	Devin M. Wells Deputy General Counsel
Address:	665 Mainstream Drive, Nashville, Tennessee
Zip:	37243
Phone:	(615) 741-1611
Email:	Devin.M.Wells@tn.gov

Revision Type (check all that apply):

___ Amendment
X New
___ Repeal

Rule(s) Revised (**ALL** chapters and rules contained in filing must be listed here. If needed, copy and paste additional tables to accommodate multiple chapters. Please enter only **ONE** Rule Number/Rule Title per row)

Chapter Number	**Chapter Title**
1200-08-37	Traumatic Brain Injury Residential Homes
Rule Number	**Rule Title**
1200-08-37-.01	Definitions
1200-08-37-.02	Licensure and Renewal
1200-08-37-.03	Fees
1200-08-37-.04	Regulatory Standards
1200-08-37-.05	Administration
1200-08-37-.06	Services Provided
1200-08-37-.07	Admissions, Discharges, and Transfers
1200-08-37-.08	Personal and Health Care Needs
1200-08-37-.09	Resident Records
1200-08-37-.10	Facility Standards
1200-08-37-.11	Building Standards
1200-08-37-.12	Life Safety
1200-08-37-.13	Infectious and Hazardous Waste
1200-08-37-.14	Reports
1200-08-37-.15	Resident Rights

1200-08-37-.16	Policies and Procedures for Health Care Decision-Making
1200-08-37-.17	Disaster Preparedness
1200-08-37-.18	Appendix I

(Place substance of rules and other info here. Statutory authority must be given for each rule change. For information on formatting rules go to http://state.tn.us/sos/rules/1360/1360.htm)

New Rule Chapter 1200-08-37
Traumatic Brain Injury Residential Homes

Table of Contents

1200-08-37-.01 Definitions.

(1) "Abuse" means the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish.

(2) "Activities of Daily Living (ADL's)" means those activities which indicate a resident's independence in eating, dressing, personal hygiene, bathing, toileting, ambulating, and medication management.

(3) "Adequate evacuation" means the ability of the TBI residential home provider or the Administrator, including such additional minimum staff as may be required by the Board in regulation, to evacuate all residents from the dwelling within five (5) minutes.

(4) "Administering medication" means the direct application of a single dose of a medication to the body of a resident by injection, inhalation, ingestion, topical application or by any other means and the placement of a single dose of medication into a container.

(5) "Administrator" means a person twenty-one (21) years of age or older who oversees the day-to-day operation of the TBI residential home on behalf of the TBI residential home provider. An Administrator shall hold national certification by the Academy of Certified Brain Injury Specialists as a Certified Brain Injury Specialist (CBIS) or hold a current license as a physician, nurse practitioner, registered nurse, licensed rehabilitation professional or licensed mental health professional trained and experienced in the care of and rehabilitation of residents with traumatic brain injury.

(6) "Adult" means a person 18 years of age or older.

(7) "Assessment" means a procedure for determining the nature and extent of the problem(s) and needs of a resident or potential resident to ascertain if the TBI residential home can adequately address those problems, meet those needs, and secure information for use in the development of the individual care plan.

(8) "Board" means the Board for Licensing Health Care Facilities.

(9) "Cardiopulmonary resuscitation (CPR)" means the administering of any means or device to restore or support cardiopulmonary functions in a resident, whether by mechanical devices, chest compressions, mouth-to-mouth resuscitation, cardiac massage, tracheal intubation, manual or mechanical ventilators or respirators, defibrillation, the administration of drugs and/or chemical agents intended to restore cardiac and/or respiratory functions in a resident where cardiac or respiratory arrest has occurred or is believed to be imminent.

(10) "CBIS" means a Certified Brain Injury Specialist who is certified by the Academy of Certified Brain Injury Specialists.

(11) "Disabled" means a resident who suffers from the effects of a traumatic brain injury.

(12) "Do-not-resuscitate order (DNR)" means a written order, other than a POST, not to resuscitate a patient in cardiac or respiratory arrest in accordance with accepted medical practices.

(13) "Elderly" means an individual who is fifty-five (55) years of age or older.

(14) "Emergency" means any situation or condition which presents an imminent danger of death or serious physical or mental harm to residents.

(15) "Exploitation" shall have the same meaning as set forth in T.C.A. § 68-11-1002.

(16) "Health care" means any care, treatment, service or procedure to maintain, diagnose, treat, or otherwise affect a resident's physical or mental condition, and includes medical care as defined in T.C.A. § 32-11-103(5).

(17) "Health care decision" means a resident's consent, refusal of consent, or withdrawal of consent to health care.

(18) "Health care decision-maker" means, in the case of a resident who lacks capacity, the resident's health care decision-maker is one of the following: the resident's health care agent as specified in an advance directive; the resident's court-appointed guardian or conservator with health care decision-making authority; the resident's surrogate as determined pursuant to T.C.A. § 68-11-1806; or the resident's designated physician pursuant to T.C.A. § 68-11-1802(a)(4).

(19) "Home like" means an environment that promotes the dignity, security and comfort of residents through the provision of personalized care and services and encourages independence, choice and decision-making by the residents.

(20) "Infectious waste" means solid or liquid waste which contains pathogens with sufficient virulence and quantity such that exposure could result in an infectious disease.

(21) "Licensed health care professional" means any health care professional currently licensed by the State of Tennessee to practice within the scope of a regulated profession, such as a nurse practitioner, registered nurse, licensed practical nurse, (nurses may be licensed or hold multistate licensure pursuant to T.C.A. §§ 63-7-101 et seq.), dietitian, dentist, occupational therapist, pharmacist, physical therapist, physician, physician assistant, psychologist, clinical social worker, respiratory therapist, speech-language pathologist, and emergency medical services personnel.

(22) "Licensee" means the person, association, partnership, corporation, company or public agency to which the license is issued. For the purposes of these rules, the term "licensee" is synonymous to "TBI residential home provider."

(23) "Medical record" means documentation of nursing notes, when applicable; medical histories; treatment records; care needs summaries; physician orders; and records of treatment and medication ordered and given which must be maintained by the TBI residential home, regardless of

whether such services are rendered by TBI residential home staff or by arrangement with an outside source.

(24) "Misappropriation of patient/resident property" means the deliberate misplacement, exploitation or wrongful, temporary or permanent use of an individual's belongings or money without the individual's consent.

(25) "NFPA" means the National Fire Protection Association.

(26) "Neglect" means the failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness; however, the withholding of authorization for or provision of medical care to any terminally ill person who has executed an irrevocable living will in accordance with the Tennessee Right to Natural Death Law, or other applicable state law, if the provision of such medical care would conflict with the terms of the living will, shall not be deemed "neglect" for purposes of these rules.

(27) "Occupant" means anyone residing in or using a TBI residential home.

(28) "Person" means an individual, association, estate, trust, corporation, partnership, joint venture, government, governmental subdivision, agency, or instrumentality, or any other legal or commercial entity.

(29) "Physician assistant" means a person who has graduated from a physician assistant educational program accredited by the Accreditation Review Commission on Education for the Physician Assistant, has passed the Physician Assistant National Certifying Examination, and is currently licensed in Tennessee as a physician assistant under title 63, chapter 19.

(30) "Physician orders for scope of treatment or POST" means written orders that:

(a) Are on a form approved by the Board for Licensing Health Care Facilities;

(b) Apply regardless of the treatment setting and that are signed as required herein by the patient's physician, physician assistant, nurse practitioner, or clinical nurse specialist; and

(c)

1. Specify whether, in the event the patient suffers cardiac or respiratory arrest, cardiopulmonary resuscitation should or should not be attempted;

2. Specify other medical interventions that are to be provided or withheld; or

3. Specify both 1 and 2.

(31) "Power of Attorney for Health Care" means the legal designation of an agent to make health care decisions for the resident who grants such power under T.C.A. § 34-6-201 et seq.

(32) "Resident" means an adult residing at the TBI residential home who suffers from the effects of a traumatic brain injury.

(33) "Residential care" means care rendered to residents who need supervision or assistance in activities of daily living. Residential care does not include nursing or medical care.

(34) "Retaliation" means increasing charges, decreasing services, rights or privileges; taking or threatening to take any action to coerce or compel the resident to leave the home; or abusing or threatening to harass or abuse a resident in any manner.

(35) "Self-administration of medication" means assistance in reading labels, opening dosage packaging, reminding residents of their medication, and observing the resident while taking medication in accordance with the plan of care.

(36) "Specialized services" means services provided to residents suffering from the effects of a traumatic brain injury.

(37) "Supervising health care provider" means the health care provider who has undertaken primary responsibility for a resident's health care.

(38) "Surrogate" means an individual, other than a resident's agent or guardian, authorized to make a health care decision for the resident pursuant to T.C.A. § 68-11-1806.

(39) "Traumatic brain injury (TBI)" means an acquired injury to the brain caused by an external physical force resulting in total or partial disability or impairment. Traumatic brain injury includes open and closed head injuries and may result in seizures, and/or mild, moderate, or severe impairment in one (1) or more areas including cognition, language, memory, attention, reasoning, abstract thinking, judgment, problem-solving, sensory, perceptual and motor abilities, psychosocial behavior, physical functions, information processing, and speech. Such term does not include brain injuries induced by birth trauma, but may include brain injuries caused by anoxia and other related causes, infectious disease not of a degenerative nature, brain tumor, toxic chemical or drug reaction.

(40) "Traumatic brain injury residential home" means a single family residence owned and operated by a community-based traumatic brain injury (TBI) adult care home provider in which residential care, including assistance with activities of daily living, is provided in a homelike environment to no more than eight (8) disabled adults suffering from the effects of a traumatic brain injury as defined in T.C.A. § 68-55-101.

(41) "Traumatic brain injury residential home provider" means a person who is twenty-one (21) years of age or older that owns and operates a TBI residential home. A traumatic brain injury residential home provider shall hold national certification by the Academy of Certified Brain Injury Specialists as a Certified Brian Injury Specialist (CBIS) or hold a current professional license as a physician, nurse practitioner, registered nurse, licensed rehabilitation professional, or licensed mental health professional who is trained and experienced in the care and rehabilitation of disabled adults suffering from the effects of a traumatic brain injury.

(42) "Treating health care provider" means a health care provider directly or indirectly involved in providing health care to a resident at the time such care is needed by the resident.

Authority: T.C.A. §§ 68-11-201, 68-11-202, and 68-11-273.

1200-08-37-.02 Licensure and Renewal.

(1) Licensure. An applicant for a TBI residential home license shall submit the following to the Board office:

(a) A completed application on a form approved by the Board;

(b) Nonrefundable application fee;

(c) The requirements contained in T.C.A. § 68-11-206(a)(1) and (2);

(d) Demonstration of the ability to meet the financial obligations of the TBI residential home with a financial statement prepared by a certified public accountant;

(e) A copy of a local business license (if one is required by the locality);

(f) A copy of any and all documents demonstrating the legal status of the business organization that owns the TBI residential home. If the applicant is a corporation or a limited liability company the applicant must submit a certificate of good standing;

(g) Proof of liability insurance; and

(h) Any other documents or information requested by the Board.

(2) Before a license is granted, the applicant shall cause to be submitted to the Board's administrative office directly from the vendor identified in the Board's licensure application materials, the result of a criminal background check.

(3) Before a license is granted, the applicant shall submit to an inspection conducted by Department of Health inspectors to ensure compliance with all applicable laws and rules.

(4) If the Board determines that a license for a TBI residential home shall not be granted, it shall notify the applicant. The decision of the board shall be final.

(5) The applicant shall not use subterfuge or other evasive means to obtain a license, such as filing for a license through a second party when an applicant has been denied a license or has had a license disciplined or has attempted to avoid the survey and review process.

(6) Renewal. TBI residential home licenses expire annually on the anniversary date of their original issuance and must be renewed by that date.

(a) In order to successfully renew a license, a licensee shall submit a completed renewal application with the applicable fee to the Board office. Department inspectors will periodically inspect each TBI residential home to determine its compliance with these rules and regulations. If the inspectors find deficiencies, the licensee shall submit an acceptable corrective action plan and shall remedy the deficiencies.

(b) Should the licensee fail to renew its license prior to the expiration date, yet within sixty (60) days after the expiration date, the licensee shall pay the licensure renewal fee and a late renewal penalty fee of one hundred dollars ($100.00) per month for each month or fraction of a month that renewal is late; provided that the late renewal penalty fee shall not exceed twice the licensure renewal fee.

(c) In the event that a licensee fails to renew its license within the sixty (60) day grace period following the license expiration date, the licensee shall reapply for a license by submitting the following to the Board office:

1. A completed application for licensure; and

2. The license fee provided in Rule 1200-08-37-.03(1).

(d) Upon reapplication, the licensee shall submit to an inspection of the TBI residential home by Department of Health inspectors.

(7) The Board shall issue a license only for the licensee and the location designated on the license application. If a TBI residential home moves to a new location, it shall obtain a new license and submit to an inspection of the new building before admitting residents.

(8) A separate license shall be required for each TBI residential home when more than one TBI residential home is operated by a TBI residential home provider.

(9) Any admission of residents to a single TBI residential home in excess of eight (8) disabled residents is prohibited.

(10) Change of Ownership.

(a) A change of ownership occurs whenever the ultimate legal authority for the responsibility of the TBI residential home's operation is transferred, including a change in the legal structure by which the TBI residential home is owned and operated and/or ownership of the preceding or succeeding entity changes.

(b) A licensee shall notify the Board's administrative office of a proposed change of ownership at least thirty (30) days prior to its occurrence by submitting the following to the Board office:

1. A completed change of ownership application on a form approved by the Board which includes all information required by Rule 1200-08-37-.02(1)(a);

2. Nonrefundable application fee;

3. Demonstration of ability to meet the financial obligations of the TBI residential home with a financial statement prepared by a certified public accountant;

4. A copy of a local business license (if one is required by the locality);

5. A copy of any and all documents demonstrating the formation of the business organization that owns the TBI residential home;

6. The bill of sale and/or closing documents indicating the transfer of operations of the business entity;

7. Comprehensive business plan for the first two years of operation;

8. Proof of liability insurance; and

9. Any other documents or information requested by the Board.

(c) Transactions constituting a change of ownership include, but are not limited to, the following:

1. Transfer of the TBI residential home's legal title;

2. Lease of the TBI residential home's operations;

3. Dissolution of any partnership that owns, or owns a controlling interest in, the TBI residential home;

4. The removal, addition or substitution of a partner;

5. Removal of the general partner or general partners, if the TBI residential home is owned by a limited partnership;

6. Merger of a TBI residential home owner (a corporation) into another corporation where, after the merger, the owner's shares of capital stock are canceled;

7. The consolidation of a corporate TBI residential home owner with one or more corporations; or

8. Transfers between levels of government.

(d) Transactions which do not constitute a change of ownership include, but are not limited to, the following:

1. Changes in the membership of a corporate board of directors or board of trustees;

2. Merger of two (2) or more corporations where one of the originally-licensed corporations survives;

3. Changes in the membership of a non-profit corporation;

4. Transfers between departments of the same level of government;

5. Corporate stock transfers or sales, even when a controlling interest;

6. Sale/lease-back agreements if the lease involves the TBI residential home's entire real and personal property and if the identity of the lessee, who shall continue the operation, retains the same legal form as the former owner; or

7. Management agreements if the owner continues to retain ultimate authority for the operation of the TBI residential home; however, if the ultimate authority is surrendered and transferred from the owner to a new manager, then a change of ownership has occurred.

(11) Qualification and Training Requirements.

(a) Qualifications for a TBI residential home provider serving residents suffering from the effects of a traumatic brain injury.

1. A TBI residential home provider serving residents with traumatic brain injury shall hold national certification by the Academy of Certified Brain Injury Specialists as a Certified Brain Injury Specialist (CBIS) or hold a current license as a physician, nurse practitioner, registered nurse, licensed rehabilitation professional or licensed mental health professional trained and experienced in the care and rehabilitation of residents with traumatic brain injury, or shall employ an Administrator who meets the qualifications specified in Rule 1200-08-37-.02(11)(a)2.

2. An Administrator for a TBI residential home serving residents with traumatic brain injury shall hold national certification by the Academy of Certified Brain Injury Specialists as a Certified Brain Injury Specialist (CBIS) or hold a current license as a physician, nurse practitioner, registered nurse, licensed rehabilitation professional or licensed mental health professional trained and experienced in the care and rehabilitation of residents with traumatic brain injury.

3. Staff members providing overnight care and/or supervision of residents in a TBI residential home shall hold national certification by the Academy of Certified Brain Injury Specialists as a Certified Brain Injury Specialist (CBIS) or hold a current license as a physician, nurse practitioner, registered nurse, licensed rehabilitation professional or licensed mental health professional trained and experienced in the care and rehabilitation of residents with traumatic brain injury and shall demonstrate competency in caring for persons with traumatic brain injury.

(b) Training. The TBI residential home provider is responsible for the supervision, training and overall conduct of the Administrator and TBI residential home staff as it relates to their job performance and responsibilities. The TBI residential home provider shall:

1. Train all staff to meet the routine and emergency needs of residents;

2. Orient all staff to the home including the location of any fire extinguishers; demonstration of evacuation procedures; location of residents' records; location of telephone numbers for the residents' physicians and other emergency contacts; location of medications and keys for medication cabinets, if applicable; instructions for caring for each resident; and delegation by a registered nurse for nursing tasks, if applicable.

3. Train the Administrator and TBI residential home staff on the health care tasks that can be administered through self-administration.

(12) Continuing Education.

(a) All TBI residential home providers and Administrators shall complete annually twelve (12) hours of continuing education related to the following topics:

1. Care of elderly persons;

2. Care of persons with disabilities;

3. Business operations of TBI residential homes; and

4. State rules and regulations for TBI residential homes.

(b) Continuing education hours offered by and/or approved by the Academy of Certified Brain Injury Specialists regarding care of elderly persons, care of persons with disabilities, and business operations of TBI residential homes will be accepted towards the twelve (12) hour continuing education requirement.

(13) The licensee shall immediately notify the Board's administrative office in the event of an absence or change of Administrator due to serious illness, incapacity, death or resignation of its named Administrator.

Authority: T.C.A. §§ 68-11-201, 68-11-202, 68-11-206, 68-11-209, 68-11-210, 68-11-270, and 68-11-273.

1200-08-37-.03 Fees.

(1) Each TBI residential home, except those operated by the United States of America or the State of Tennessee, making application for licensure under this chapter shall pay annually to the Board's administrative office, a fee in the amount of $1,080.00.

Authority: T.C.A. §§ 68-11-202, 68-11-216, and 68-11-273.

1200-08-37-.04 Regulatory Standards.

(1) A Department of Health representative shall make an unannounced inspection of every TBI residential home holding a license granted by the Board for its compliance with applicable state law and regulations within fifteen (15) months following the date of its last inspection, and as necessary, to protect the public's health, safety and welfare, with the first unannounced inspection completed prior to the first annual license renewal. A TBI residential home must cooperate during Department of Health conducted inspections, including allowing entry at any hour and providing all required records.

(2) A Department of Health investigator, as the Board's representative, shall be permitted access to enter and inspect any TBI residential home upon the receipt of an oral or written complaint; any time the Board has cause to believe that a TBI residential home is operating without a license; or any time there exists a threat to the health, safety or welfare of any resident.

(3) A Department of Health investigator, as the Board's representative, shall investigate all complaints within timeframes established in applicable statutes or regulations, or as expeditiously as necessary to ensure the health, safety and welfare of TBI residential home residents.

(a) The investigation findings shall be reported to the Board in an anonymous probable cause presentation.

(b) Once the Board determines the appropriate discipline, the TBI residential home provider shall be informed by written correspondence.

(c) The Board shall notify the complainant of the complaint's resolution.

(d) The Board shall maintain a file of reported complaints which includes the name of the TBI residential home provider against whom the complaint is filed; the date the complaint is filed; the action taken by the board on the complaint; and date of action taken.

(4) Plan of Correction. When Department of Health inspectors find that a TBI residential home has committed a violation of this chapter, including a violation(s) resulting in a suspension of admissions, the Department of Health, as the Board's representative, will issue a statement of deficiencies to the TBI residential home. Within ten (10) days of receipt of the statement of deficiencies, the TBI residential home must return a plan of correction including the following:

(a) How the deficiency will be corrected;

(b) The date upon which each deficiency will be corrected;

(c) What measures or systemic changes will be put in place to ensure that the deficient practice does not recur; and

(d) How the corrective action will be monitored to ensure that the deficient practice does not recur.

(5) Either failure to submit a plan of correction in a timely manner or a finding by the Department of Health that the plan of correction is unacceptable may subject the TBI residential home's license to disciplinary action.

(6) Upon a finding by the Board that a TBI residential home has violated any provision of the Health Facilities and Resources Act, Part 2—Regulation of Health and Related Facilities (T.C.A. §§ 68-11-201, et seq.) or the rules promulgated pursuant thereto, action may be taken, upon proper notice to the licensee, to deny, suspend, revoke or place the facility's license on probation in accordance with T.C.A. § 68-11-207(f).

(7) Civil Penalties. The Board may, in a lawful proceeding respecting licensing (as defined in the Uniform Administrative Procedures Act, T.C.A. § 4-5-101, et seq.), in addition to or in lieu of other lawful disciplinary action, assess civil penalties for serious violations of statutes, rules or orders resulting in endangerment to the health, safety and welfare of residents enforceable by the Board in accordance with the following schedule:

Violation	Penalty
Failure to have adequate staffing.	$ 500 - $5000
Failure to maintain personal and medical records.	$ 0 - $1000
Failure to provide appropriate medical and other professional services.	$ 0 - $1000
Failure to provide appropriate non-medical living assistance services (assistance with ADLs).	$ 0 - $1000
Failure to create and/or maintain a plan of care.	$ 0 - $1000
Failure to conduct an admission assessment.	$ 0 - $1000
Failure to abide by applicable fire safety. regulations	$ 0 - $1000
Admitting residents over the licensed capacity.	$ 500 - $1000
Admission or retention of inappropriately placed resident. T.C.A. § 68-11-213(i)(2) (Each resident shall constitute a separate violation.)	$ 0 - $3000
Operating a TBI residential home without required license. T.C.A. § 68-11-213(i)(1)	$1000 - $5000

(Each day of operation shall constitute a separate violation)

In determining the amount of any civil penalty to be assessed pursuant to this rule the Board may consider such factors as the following:

(a) Willfulness of the violation.

(b) Repetitiveness of the violation.

(c) Magnitude of the risk of harm caused by the violation.

(8) Each violation of any statute, rule or order enforceable by the Board shall constitute a separate and distinct offense and may render the TBI residential home committing the offense subject to a separate penalty for each violation.

(9) A TBI residential home provider may appeal any disciplinary action taken against it in accordance with the Uniform Administrative Procedures Act, T.C.A. § 4-5-101, et seq.

(10) Reconsideration and Stays. The Board authorizes the member who chaired the Board for a contested case to be the agency member to make the decisions authorized pursuant to Rule 1360-04-01-.18 regarding petitions for reconsiderations and stays in that case.

Authority: T.C.A. §§ 68-11-202, 68-11-207, 68-11-209, 68-11-210, 68-11-213, and 68-11-273.

1200-08-37-.05 Administration.

(1) Each TBI residential home shall meet the following staffing standards:

(a) A TBI residential home provider shall employ an Administrator to oversee the day-to-day operation of the TBI residential home when the TBI residential home provider is unavailable. The Administrator shall meet the education, experience and training requirements of a TBI residential home provider required by the Board.

(b) A TBI residential home provider shall employ staff members to supervise the residents at all times while in the home, including overnight and during weekends. Staff members providing overnight care and/or supervision shall hold national certification by the Academy of Certified Brain Injury Specialists as a Certified Brain Injury Specialist (CBIS) or hold a current license as a physician, nurse practitioner, registered nurse, licensed rehabilitation professional or licensed mental health professional trained and experienced in the care of and rehabilitation of residents with traumatic brain injury.

(c) A TBI residential home provider is not required to live in the home or to employ a resident manager or a substitute caregiver to live in the home.

(d) TBI residential home staff shall:

1. Be awake and available to meet the routine and emergency service needs of the residents twenty-four (24) hours a day;

2. Demonstrate documented competency in providing care for residents requiring specialized services;

3. Evacuate all residents within five (5) minutes or less;

4. Know how to operate the generator without assistance and be able to demonstrate its operation upon request.

5. Coordinate with primary care physicians, specialists, and other health care professionals as appropriate.

6. Be at least eighteen (18) years of age.

(e) A TBI residential home shall employ a qualified dietitian, full time, part-time, or on a consultant basis.

(f) A TBI residential home shall not employ an individual listed on the Abuse Registry maintained by the Department of Health.

(2) Each TBI residential home shall meet the following procedural standards:

(a) Policies and Procedures:

1. A TBI residential home shall have a written statement of policies and procedures outlining the TBI residential home's responsibilities to its residents, any obligations residents have to the home, and methods by which residents may file grievances and complaints.

2. A TBI residential home provider shall develop and implement an effective facility-wide performance improvement plan that addresses plans for improvement for self-identified deficiencies and documents the outcome of remedial action.

3. A TBI residential home provider shall develop a written policy, plan or procedure concerning a subject and adhere to its provisions whenever required to do so by these rules. A TBI residential home that violates its own policy established as required by these rules and regulations also violates the rules and regulations establishing the requirement.

4. A TBI residential home provider shall develop a written policy and procedure governing smoking practices of residents.

(i) Residents of the home are exempt from the smoking prohibition.

(ii) Smoke from permissible smoking areas shall not infiltrate into areas where smoking is prohibited.

5. A TBI residential home shall develop a concise statement of its charity care policies and shall post such statement in a place accessible to the public.

(b) Resident grievances:

1. The TBI residential home provider shall inform each resident verbally and in writing of the resident's right to file a complaint with the state at any time; the process for filing a complaint; and contact information for filing a complaint. Verbal and written communication to the resident shall indicate, at a minimum that:

(i) Complaints regarding suspected abuse, neglect, misappropriation of patient/resident property, or exploitation shall be reported to adult protective services;

(ii) Complaints regarding licensure shall be reported to the Board; and

(iii) All other complaints shall be reported to the appropriate state designated oversight entity.

2. The TBI residential home provider shall advise residents of the availability of a long-term care ombudsman, and how to contact such ombudsman for assistance.

3. The TBI residential home provider shall forward all complaints to the appropriate state oversight entity.

4. The TBI residential home provider shall not prohibit or discourage the filing of complaints or use intimidation against any person for filing a complaint.

5. The TBI residential home provider shall not retaliate against the resident or the person acting on behalf of the resident in any way.

6. Persons acting in good faith in filing a complaint are immune from any liability, civil or criminal.

(c) Allegations of abuse, neglect, misappropriation of patient/resident property, or exploitation: A TBI residential home shall place a TBI residential home provider, an Administrator, or TBI residential home staff against whom an allegation of abuse, neglect, misappropriation of patient/resident property, or exploitation has been made on administrative leave of absence until the investigation conducted by the appropriate state entity is complete.

(d) A TBI residential home shall keep a written up-to-date log of all residents that can be produced in the event of an emergency.

(e) A TBI residential home may allow pets in the TBI residential home only when they are not a nuisance and do not pose a health hazard. Plans for pet management must be approved by the Department. Proof of rabies vaccinations and any other vaccinations that are required for the pet by a licensed veterinarian must be maintained on the premises.

(f) No person associated with the licensee or TBI residential home shall act as a court-appointed guardian, trustee, or conservator for any resident of the TBI residential home or any of such resident's property or funds.

(3) A TBI residential home shall post the following at the main public entrance or other equally prominent place in the TBI residential home:

(a) A statement that a resident who may be the victim of abuse, neglect, misappropriation of patient/resident property, or exploitation may seek assistance or file a complaint with the Division of Adult Protective Services. The statement shall include the statewide toll-free number for the Division and the telephone number for the local district attorney's office. The posting shall be on a sign no smaller than eleven (11") inches in width and seventeen (17") inches in height. (This same information shall be provided to each resident in writing upon admission to any home.)

(b) A statement that any person, regardless of age, who may be the victim of domestic violence may call the nationwide domestic violence hotline for immediate assistance, with that number printed in boldface type, and posted on a sign no smaller than eight and one-half inches (8½") in width and eleven inches (11") in height;

(c) A statement that the TBI residential home has liability insurance; the identity of the primary insurance carrier; and if self-insured, the corporate entity responsible for payment of any claims. It shall be posted on a sign no smaller than eleven inches (11") in width and seventeen inches (17") in height;

(d) "No Smoking" signs or the international "No Smoking" symbol, consisting of a pictorial representation of a burning cigarette enclosed in a red circle with a red bar across it, shall be clearly and conspicuously posted at every entrance;

(e) A statement that any person who has experienced a problem with a specific licensed TBI residential home may file a complaint with the Division of Health Care Facilities. The posting shall include the statewide toll-free telephone number for the Division's centralized complaint intake unit; and

(f) A copy of the resident's rights.

(4) Infection Control.

(a) A TBI residential home shall ensure that neither a resident nor an employee of the TBI residential home with a reportable communicable disease shall reside or work in the TBI residential home unless the TBI residential home has a written protocol approved by the Board's administrative office.

(b) A TBI residential home shall have an annual influenza vaccination program which shall include at least:

1. The offer of influenza vaccination to all staff and independent practitioners or accept documented evidence of vaccination from another vaccine source or facility;

2. A signed declination statement on record from all who refuse the influenza vaccination for other than medical contraindications;

3. Education of all direct care personnel about the following:

(i) Influenza vaccination;

(ii) Non-vaccine control measures; and

(iii) The diagnosis, transmission, and potential impact of influenza;

4. An annual evaluation of the influenza vaccination program and reasons for non-participation; and

5. A statement that the requirements to complete vaccinations or declination statements shall be suspended by the TBI residential home provider in the event of a vaccine shortage.

(c) A TBI residential home and its staff shall adopt and utilize standard precautions in accordance with guidelines established by the Centers for Disease Control and Prevention (CDC) for preventing transmission of infections, HIV, and communicable diseases, including adherence to a hand hygiene program which shall include:

1. Use of alcohol-based hand rubs or use of non-antimicrobial or antimicrobial soap and water before and after each resident contact if hands are not visibly soiled;

2. Use of gloves during each resident contact with blood or where other potentially infectious materials, mucous membranes, and non-intact skin could occur and gloves shall be changed before and after each resident contact;

3. Use of either a non-antimicrobial soap and water or an antimicrobial soap and water for visibly soiled hands; and

4. Health care worker education programs which may include:

(i) Types of resident care activities that can result in hand contamination;

(ii) Advantages and disadvantages of various methods used to clean hands;

(iii) Potential risks of health care workers' colonization or infection caused by organisms acquired from residents; and

(iv) Morbidity, mortality, and costs associated with health care associated infections.

(d) A TBI residential home provider shall develop and implement a system for measuring improvements in adherence to the hand hygiene program and influenza vaccination program.

(5) A TBI residential home shall ensure that no person will be excluded from participation in, be denied benefits of, or be otherwise subjected to discrimination in the provision of any care or service of the TBI residential home on the grounds of race, color, national origin, or handicap. A TBI residential home shall protect the civil rights of residents under the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973.

Authority: T.C.A. §§ 39-17-1804, 39-17-1805, 68-11-202, 68-11-206, 68-11-207, 68-11-209, 68-11-268, 68-11-269, 68-11-270, 68-11-271, and 68-11-273.

1200-08-37-.06 Services Provided.

(1) Each TBI residential home shall provide twenty-four (24) hour staffing coverage that is adequate to meet the needs of residents. This will include both the residences and the day service facility under separate license, if any. Staffing and clinical expertise should correspond to the residents being served. TBI residential home providers shall coordinate with primary care physicians, specialists, and other health care professionals as appropriate.

(2) Traumatic brain injury residential home providers shall provide community-based care for their residents in addition to residential care, as provided in the resident's plan of care. During weekdays, the residents shall be provided day services through a separate facility licensed by the state. On weekends, the residents shall participate in community activities, including, but not limited to, church attendance, visits to local parks, and other recreational activities of their choice or the choice of their family or legal representatives, as provided in the resident's plan of care.

(3) As an alternative to the licensing condition of off-site day services, a TBI residential home serving only private pay or private insurance residents may provide day services for the residents on site as part of the comprehensive services provided.

(4) Medical services in a TBI residential home, when needed, shall be provided by:

(a) Appropriately licensed staff of a TBI residential home;

(b) Appropriately licensed or qualified contractors of a TBI residential home;

(c) A licensed home care organization; or

(d) Another appropriately licensed entity.

(5) Standards for Medication Administration. A TBI residential home shall:

(a) Ensure that all drugs and biologicals shall be administered by a licensed professional operating within the scope of the professional license and according to the resident's plan of care; and

(b) Ensure that all medications are kept in a locked, central location, separate from medications of the staff.

(c) Self-administration of Medication. Residents must have a physician or nurse practitioner's written order of approval to self-medicate. Residents able to handle their own medical regimen may keep medications in their own room in a locked storage container.

(d) Injections. Subcutaneous, intramuscular, and intravenous injections may be self-administered by the resident or by a licensed professional operating within the scope of the professional license.

(6) A TBI residential home shall dispose of medications as follows:

(a) Upon discharge of a resident, unused prescription medication shall be released to the resident, the resident's family member, or the resident's legal representative, unless specifically prohibited by the attending physician.

(b) Upon death of a resident, unused prescription medication must be destroyed in the manner outlined and by the person(s) designated in the home's medication disposal policy, unless otherwise requested by the resident's family member or the resident's legal representative and accompanied by a written order by a physician. The home's medication disposal policy shall be written in accordance with current FDA or current DEA medication disposal guidelines.

(c) The home shall properly dispose of prescription medication administered by the home in accordance with the home's medication disposal policy.

(d) The home may dispose of prescription medication that is self-administered by the resident in accordance with the home's medication disposal policy or provide information to the resident's family member or the resident's legal representative regarding the proper method to dispose of the medication.

(e) If the resident is a hospice patient, hospice shall be responsible for disposing of the prescription medication upon death of the resident.

(7) A TBI residential home shall provide residential care to its residents as follows:

(a) Each TBI residential home shall provide each resident with at least the following residential care:

1. Protective care;

2. Safety when in the TBI residential home;

3. Daily awareness of the resident's whereabouts;

4. The ability and readiness to intervene if crises arise;

5. Room and board; and

6. Non-medical living assistance with activities of daily living.

(b) Laundry services. A TBI residential home shall:

1. Provide laundry equipment and supplies necessary for the cleaning of TBI residential home linens and residents' clothing;

2. Provide appropriate separate storage areas for soiled linens and residents' clothing; and

3. Maintain clean linens in sufficient quantity to provide for the needs of the residents. Linens shall be changed whenever necessary.

(c) Dietary services.

1. A TBI residential home provider shall provide three (3) nutritionally balanced meals per day or shall make arrangements for meals on an as needed basis. The food must be adapted to the habits, preferences and physical abilities of the residents. Additional nourishment and/or snacks shall be provided to residents with special dietary needs or upon request.

2. There shall be no more than fourteen (14) hours between the evening and morning meals.

3. All food served to the residents shall be of good quality and variety, sufficient quantity, attractive and at safe temperatures. Prepared foods shall be kept hot (140° F or above) or cold (41° F or less) as appropriate.

4. Meal planning and preparation shall take into consideration any special dietary needs of the resident, as prescribed by the resident's physician.

5. A TBI residential home provider shall designate a person responsible for the food service, including the purchasing of adequate food supplies and the maintenance of sanitary practices in good storage preparation and distribution. Sufficient arrangements or employees shall be maintained to cook and serve the food.

6. A TBI residential home provider may contract with an outside food management company if the company has a dietitian who serves the TBI residential home on a full-time, part-time, or consultant basis, and if the company maintains at least the minimum standards specified in this section while providing for constant liaison with the TBI residential home for recommendations on dietetic policies affecting resident treatment.

7. A TBI residential home shall have a current therapeutic diet manual approved by a dietitian readily available to all TBI residential home personnel.

8. Menus shall be planned one week in advance and posted in a location accessible to residents and families.

9. A TBI residential home shall:

   (i) Provide sufficient food provision capabilities and dining space.

   (ii) Maintain and properly store a forty-eight (48) hour food supply at all times.

   (iii) Provide appropriate, properly-repaired equipment and utensils for cooking and serving food to serve all residents.

   (iv) Maintain a clean and sanitary kitchen.

   (v) Ensure employees shall wash and sanitize equipment, utensils and dishes after each use.

Authority: T.C.A. §§ 68-11-202, 68-11-206, 68-11-209, 68-11-270, 68-11-273, and 68-11-274.

1200-08-37-.07 Admissions, Discharges, and Transfers.

(1) Admissions.

(a) A TBI residential home may only admit and continue to care for residents requiring specialized services, where assistance is provided with ADL's in a homelike environment.

(b) A TBI residential home may not admit or serve a resident who is ventilator dependent.

(c) A TBI residential home may serve up to eight (8) disabled adults, who suffer from the effects of a traumatic brain injury and who are unrelated to the TBI residential home provider by blood or marriage.

(d) A TBI residential home provider may choose to serve one (1) or more elderly adult members of their own family as long as the TBI residential home provider serves at least two (2) additional disabled adults unrelated to the TBI residential home provider by blood or marriage. In no event shall a TBI residential home provider serve more than eight (8) disabled residents in the licensed TBI residential home.

(e) A TBI residential home may not admit or retain a resident who cannot be evacuated within five (5) minutes.

(f) A TBI residential home shall upon admission of a resident:

1. Be able to identify at the time those residents whose needs for services are consistent with these rules and regulations, and those residents who should be transferred to a more appropriate level of care;

2. Document plans and procedures to show evacuation of the resident within five (5) minutes.

3. Provide to each resident a written admission agreement signed and dated by the TBI residential home provider and the resident or the resident's family member or the resident's legal representative and presented both verbally and in writing. The admission agreement shall be reviewed and updated as necessary as a part of the residential plan of care review process and contain the following:

   (i) A copy of the resident rights for the resident's review and signature;

   (ii) A copy of house rules and the rate schedules, including any payment for services for which the resident will be responsible;

   (iii) An accurate written statement providing that the TBI residential home provider shall give thirty (30) days written notice to the resident prior to making any changes in the rates;

   (iv) The consequences for non-payment for services which includes involuntary discharge from the TBI residential home;

   (v) An accurate written statement regarding services which will be provided residents upon admission;

   (vi) Procedures for handling the transfer or discharge of residents that does not violate the residents' rights under the law or these rules;

   (vii) A copy of the medication disposal policy.

4. Disclose in writing to the resident or to the resident's legal representative, the identity of the TBI residential home's primary liability insurance carrier. If the TBI residential home is self-insured, its statement shall reflect that fact and indicate the corporate entity responsible for payment of any claims;

5. Document evidence of annual vaccination against influenza for each resident, in accordance with the recommendation of the Advisory Committee on Immunization Practices of the Centers for Disease Control most recent to the time of vaccine, unless such vaccination is medically contraindicated or the resident or the resident's legal representative has refused the vaccine. Influenza vaccination for all residents accepting the vaccine shall be completed by November 30 of each year or within ten (10) days of the vaccine becoming available. Residents admitted after this date during the flu season and up to February 1, shall, as medically appropriate, receive influenza vaccination prior to or on admission unless refused by the resident or the resident's legal representative; and

6. Document evidence of vaccination against pneumococcal disease for all residents who are sixty-five (65) years of age or older, in accordance with the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control at the time of vaccination, unless such vaccination is medically contraindicated or the resident or the resident's legal representative has refused the offer of vaccine. The TBI

residential home shall provide or arrange for the pneumococcal vaccination of residents who have not received this immunization prior to or on admission unless the resident or resident's legal representative refuses offer of the vaccine.

(2) Discharges and Transfers.

(a) Residents may only be moved, transferred or discharged from a TBI residential home for the following reasons:

1. Medical reasons. The resident has a medical or nursing condition that exceeds the level of health care services the home provides;

2. Welfare of the resident or of other residents. This includes, but is not limited to the following: The TBI residential home is unable to accomplish timely evacuation of the resident in the event of an emergency; the resident exhibits behavior that poses an imminent danger to self or others; the resident engages in behavior or actions that repeatedly and substantially interfere with the rights, health or safety of residents or others; or the resident engages in illegal drug use, or commits a criminal act that causes potential harm to the resident or others;

3. Nonpayment for services provided to the resident by the home; or

4. Closing or selling the home.

(b) A TBI residential home resident shall be discharged and transferred to another appropriate setting such as home, a hospital, or a nursing home when the resident, the resident's legal representative, or the resident's treating physician determines that the TBI residential home cannot safely and effectively meet the resident's needs, including medical services.

(c) The Board may require that a TBI residential home resident be discharged or transferred to another level of care if it determines that the resident's needs, including medical services, cannot be safely and effectively met in the TBI residential home.

(d) In the event of a discharge or transfer due to medical reasons, for the welfare of the resident or for the welfare of other residents, or due to nonpayment for services provided to the resident by the home, the TBI residential home provider shall give the resident, the resident's family member, or the resident's legal representative written notice at least thirty (30) days prior to the proposed transfer or discharge.

(e) In the event of a discharge or transfer due to medical reasons, the welfare of the resident, or for the welfare of other residents, the TBI residential home provider shall work with the Board to develop a transition plan in order to maintain continuity of care for the resident and to minimize the impact of the transition. The TBI residential home provider shall assist the resident in locating an alternate appropriate setting.

(f) In the case of a medical emergency that requires immediate action, the TBI residential home provider shall give the resident, the resident's family member, or the resident's legal representative written notice as soon as possible under the circumstances.

(g) In the event of discharge or transfer due to selling the home to another TBI residential home provider, the current TBI residential home provider shall develop a transition plan for all residents to facilitate the transition to a new TBI residential home and shall maintain its license and operation of the home until the point in time the new TBI residential home's license is approved.

(h) In the event of discharge or transfer due to the closing of the home, the TBI residential home provider shall provide ninety (90) days advance notice to residents and shall work with the Board to develop a transition plan to maintain continuity of care for the residents and to

minimize the impact of transition. The TBI residential home shall assist each resident in locating an alternative placement.

Authority: T.C.A. §§ 68-11-202, 68-11-206, 68-11-209, 68-11-270, and 68-11-273.

1200-08-37-.08 Personal and Health Care Needs.

(1) A TBI residential home provider shall conduct an assessment of a prospective resident before admitting the resident. The assessment shall include:

(a) Diagnoses;

(b) Medications;

(c) Personal care needs;

(d) Health care needs;

(e) Nutritional needs;

(f) Activities; and

(g) Lifestyle preferences.

(2) A TBI residential home provider shall be able to meet the needs of a resident, including personal and health care needs and night care needs, before admitting the resident.

(3) Plan of Care.

(a) The TBI residential home shall develop a resident plan of care for the day-to-day delivery of residential services, including personal and health care needs and night care needs with input and participation from the resident or the resident's legal representative, the resident's family, and the resident's treating physician or other licensed health care professionals or entity delivering patient services within five (5) days of admission.

(b) The plan of care shall include, at a minimum the following elements:

1. Health and functional status, including cognitive/behavioral health status and any ADL deficiencies;

2. Resident needs and preferences, personal and health care needs, and night care needs;

3. Significant health conditions and required course of treatment for management of chronic conditions;

4. Medication regimen;

5. Any healthcare tasks that have been ordered by a healthcare professional that will be performed by the traumatic brain injury residential home provider under the self-direction of the resident or of the resident's family member;

6. Identification of risks to health and safety;

7. Strategies to mitigate identified risks; and

8. Activities in the community for which the resident, the resident's family, or legal representative has an interest, including, but not limited to, church attendance, visits to local parks, and other recreational activities.

(c) The plan of care shall be reviewed quarterly and updated, at a minimum, on an annual basis and more frequently as the resident's health status changes and as circumstances warrant.

Authority: T.C.A. §§ 68-11-202, 68-11-206, 68-11-209, 68-11-270, and 68-11-273.

1200-08-37-.09 Resident Records.

(1) A TBI residential home provider shall develop and maintain an organized record for each resident and ensure that all entries shall be written legibly in ink, typed, or kept electronically, and signed, and dated. The provider shall keep a current record of active cases in the home. Historical records for each resident may be kept in the home or at the TBI residential home's home office.

(2) Personal record. A TBI residential home provider shall ensure that the resident's personal record includes at a minimum the following:

(a) Name, social security number, veteran status and number, marital status, age, sex, any health insurance provider and number, including Medicare and/or Medicaid number, and photograph of the resident;

(b) Name, address and telephone number of next of kin, legal representative (if applicable), and any other person identified by the resident to contact on the resident's behalf;

(c) Name and address of the resident's preferred physician, hospital, pharmacist and nursing home, and any other instructions from the resident to be followed in case of emergency;

(d) Record of all monies and other valuables entrusted to the TBI residential home for safekeeping, with appropriate updates;

(e) Date of admission, transfer, discharge and any new forwarding address;

(f) A copy of the admission agreement that is signed and dated by the resident;

(g) A copy of any advance directives, DNR Order, Durable Power of Attorney, or living will, when applicable, and made available upon request; and

(h) A record that the resident has received a copy of the TBI residential home's resident's rights and procedures policy.

(3) Medical record. A TBI residential home provider shall ensure that its staff develop and maintain a medical record for each resident who requires health care services at the TBI residential home regardless of whether such services are rendered by the TBI residential home or by resident self-direction, which shall include at a minimum:

(a) Medical history;

(b) Consultation by physicians or other authorized healthcare providers;

(c) Orders and recommendations for all medication, medical and other care, services, procedures, and diet from physicians or other authorized healthcare providers, which shall be completed prior to, or at the time of admission, and subsequently, as warranted. Verbal orders received shall include the time of receipt of the order, description of the order, and identification of the individual receiving the order;

(d) Medication Administration Record (MAR). A current, written medication administration record must be kept for each resident and must:

1. List the name of all medications administered by licensed staff, including over-the-counter medications and prescribed dietary supplements;

2. Identify the dosage, route, and the date and time each medication or supplement is to be given;

3. Identify any treatments and therapies given by licensed staff. The record must indicate the type of treatment or therapy and the time the procedure is to be performed;

4. Immediately be initialed by the licensed staff administering the medication, treatment or therapy as it is completed. Each medication administration record must contain a legible signature that identifies each set of initials;

5. Document changes and discontinued orders immediately, showing the date of the change or discontinued order; and

6. Document missed or refused medications, treatment or therapies.

(e) Procedures followed in the event a medication error is made;

(f) Special procedures and preventive measures performed;

(g) Notes, including, but not limited to, observation notes, progress notes, and nursing notes;

(h) Listing of current vaccinations;

(i) Time and circumstances of discharge or transfer, including condition at discharge or transfer, or death;

(j) Provisions of routine and emergency medical care, to include the name and telephone number of the resident's physician, plan for payment, and plan for securing medications; and

(k) Special information, e.g., allergies, etc.

(4) Personal information shall be confidential and shall not be disclosed, except to the resident, the Department of Health and others with written authorization from the resident. Records shall be retained for three (3) years after the resident has been transferred or discharged.

Authority: T.C.A. §§ 68-11-202, 68-11-206, 68-11-209, 68-11-270, and 68-11-273.

1200-08-37-.10 Facility Standards.

(1) General.

(a) TBI residential homes shall be operated and maintained to ensure a homelike environment.

(b) Hardware for all exit and interior doors must have simple hardware that cannot be locked against exit and must have an obvious method of operation. Hasps, sliding bolts, hooks and eyes, and double key deadbolts are not permitted.

(c) Sleeping rooms for all household occupants must be finished with wall or partitions of standard construction which go from floor to ceiling; have a door which opens directly to a hallway or common use room without passage through another bedroom or common room; and be adequately ventilated, heated and lighted, with at least one window that opens which meets fire safety regulations.

(d) TBI residential home providers, TBI residential home staff, and family members shall not sleep in areas designated as living areas or common use areas.

(2) Resident sleeping rooms.

(a) Each resident shall have his or her own sleeping room, not to be shared with any other resident or staff member.

(b) Each resident sleeping room must be a minimum of one hundred and twenty (120) square feet, or larger when necessary to accommodate the necessary equipment and supplies for the care and services needed for the resident.

(c) Each resident sleeping room must have at least one window or exterior door that will readily open from the inside without special tools and which provides a clear opening of not less than eight hundred twenty one (821) square inches (5.7 square feet), with the least dimensions not less than twenty two (22) inches in height or twenty (20) inches in width. Sill height must not be more than forty-four (44) inches from the floor level or there must be approved steps or other aids to the window exit.

(d) Each resident sleeping room must be in close enough proximity to the staff person(s) in charge to alert him or her to nighttime needs or emergencies. Otherwise, each resident sleeping room must be equipped with a call bell or intercom that will enable residents to summon staff's assistance when needed. The summons must be audible in all areas of the TBI residential home. Intercoms must not violate the resident's right to privacy and must have the capability of being turned off by the resident or at the resident's request.

(e) Each resident sleeping room must be equipped with an individual bed consisting of a mattress and springs, in good condition. Each bed must have clean bedding in good condition consisting of bedspread, mattress pad, two sheets, a pillow, a pillowcase and blankets adequate for the weather.

(f) Each resident sleeping room must have a private dresser and closet space sufficient for the resident's clothing and personal effects including hygiene and grooming supplies. Residents must be allowed to keep and use reasonable amounts of personal belongings.

(g) Drapes or shades for windows must be provided and must be in good condition and allow privacy for residents.

(h) TBI residential home providers shall not place residents who are unable to walk without assistance or who are incapable of independent evacuation in a basement, split-level, second story or other area that does not have an exit at the ground level.

(i) Each resident sleeping room must have a second safe means of exit. A second safe means of exit means that there must be two ways to safely exit the TBI residential home from a resident sleeping room. TBI residential home providers with resident sleeping rooms above the first floor shall be required to demonstrate an evacuation drill from that resident sleeping room, using the secondary exit, at the time of licensure, renewal, or inspection.

(3) Common use areas.

(a) Common use areas must be accessible to all residents and may include the dining room and the living room.

(b) Each common use area shall have at a minimum one hundred fifty (150) square feet of common living space and sufficient furniture to accommodate the recreational and social needs.

(c) Common use areas must not be located in an unfinished basement or a garage.

(4) Bathrooms.

(a) Bathrooms must provide individual privacy with a door which opens to a hall or common use room; a mirror; a window that opens or other means of ventilation; and a window covering for privacy. A resident may have a bathroom that opens into the resident's own bedroom instead

of opening to a hall or common use room, provided that no resident shall have to walk through another resident's sleeping room to get to a bathroom.

(b) Bathrooms must be clean and free of objectionable odors.

(c) Bathrooms must have bathtubs and/or showers, toilets and sinks in good repair.

(d) There must be at least one toilet, one sink and one bathtub or shower for every three (3) household occupants.

(e) Non-slip floor surfaces must be provided in bathtubs and showers.

(f) Bathrooms must have grab bars for each toilet, bathtub and shower.

(g) Each bathroom shall have an adequate supply of toilet paper and soap.

(h) Each bathroom shall have appropriate racks or hooks for drying bath linens.

(i) Each bathroom shall have hand towels or roller-dispensed hand towels or paper towels.

(j) The TBI residential home provider shall supply residents with clean, individual towels and washcloths.

(5) Each TBI residential home shall provide the following:

(a) Current newspapers, magazines or other reading materials;

(b) A telephone accessible to all residents to make and receive personal telephone calls twenty-four (24) hours per day; and

(c) A suitable and comfortable furnished area for activities and family visits. Furnishings shall include a calendar and a functioning television set, radio and clock.

Authority: T.C.A. §§ 68-11-202, 68-11-206, 68-11-209, 68-11-270, and 68-11-273.

1200-08-37-.11 Building Standards.

(1) The physical plant and the overall environment of a TBI residential home shall be constructed, arranged, and maintained in such a manner that the safety and well-being of residents are assured.

(2) A TBI residential home shall be of sound construction with wall and ceiling flame spread rates at least substantially comparable to wood lath and plaster or better. The maximum flame spread of finished materials must not exceed Class III (76-200) and smoke density must not be greater than four hundred and fifty (450). If more than ten percent (10%) of combined wall and ceiling areas in a sleeping room or exit way is composed of readily combustible material, such material must be treated with an approved flame retardant coating unless the home is supplied with an approved automatic sprinkler system.

(3) After the applicant has submitted an application and licensure fees, the applicant must submit the building construction plans to the Department. All new facilities shall conform to the current edition of the International Building Code, the National Fire Protection Association Code (NFPA), the National Electrical Code, and the U.S. Public Health Service Food Code, as adopted by the Board for Licensing Health Care Facilities. When referring to height, area, or construction type, the International Building Code shall prevail. All new and existing facilities are subject to the requirements of the Americans with Disabilities Act (A.D.A.). Where there are conflicts between requirements in local codes, the above listed codes and regulations and provisions of this chapter, the most stringent requirements shall apply.

(4) The codes in effect at the time of submittal of plans and specifications, as defined by these rules, shall be the codes to be used throughout the project.

(5) The licensed contractor shall perform all new construction and renovations to TBI residential homes, other than minor alterations not affecting fire and life safety or functional issues, in accordance with the specific requirements of these regulations governing new construction in TBI residential homes, including the submission of phased construction plans and the final drawings and the specifications to each.

(6) No new TBI residential home shall be constructed, nor shall major alterations be made to an existing TBI residential home without prior approval of the Department of Health, and unless in accordance with plans and specifications approved in advance by the Department. Before any new TBI residential home is licensed or before any alteration or expansion of a licensed TBI residential home can be approved, the applicant must furnish one (1) complete set of plans and specifications to the Department for an existing single family dwelling or two (2) complete sets of plans and specifications to the Department for a new construction, together with fees and other information as required.

(7) Final working drawings and specifications shall be accurately dimensioned and include all necessary explanatory notes, schedules and legends. The working drawings and specifications shall be complete and adequate for contract purposes.

(8) Detailed plans shall be drawn to a scale of at least one-eighth inch equals one foot (1/8" = 1'), and shall show the general arrangement of the building, the intended purpose and the fixed equipment in each room, with such additional information as the Department of Health may require. An architect or engineer licensed to practice in the State of Tennessee shall prepare the plans the Department requires.

(a) The project architect or engineer shall forward the appropriate number of plans to the appropriate section of the Department for review. After receipt of approval of phased construction plans, the owner may proceed with site grading and foundation work prior to receipt of approval of final plans and specifications with the owner's understanding that such work is at the owner's own risk and without assurance that final approval of final plans and specifications shall be granted. The project architect or engineer shall submit final plans and specifications for review and approval. The Department must grant final approval before the project proceeds beyond foundation work.

(b) Review of plans does not eliminate responsibility of owner and/or architect to comply with all rules and regulations.

(9) Specifications shall supplement all drawings. They shall describe the characteristics of all materials, products and devices, unless fully described and indicated on the drawings. Specification copies should be bound in an 8½ x 11 inch folder.

(10) Drawings and specifications shall be prepared for each of the following branches of work: Architectural, Structural, Mechanical, Electrical and Sprinkler.

(11) Architectural drawings shall include, where applicable:

(a) Plot plan(s) showing property lines, finish grade, location of existing and proposed structures, roadways, walks, utilities and parking areas;

(b) Floor plan(s) showing scale drawings of typical and special rooms indicating all fixed and movable equipment and major items of furniture. Floor plan(s) shall indicate the size of each room;

(c) Separate life safety plans showing the compartment(s), all means of egress and exit markings, exits and travel distances, dimensions of compartments and calculation and tabulation of exit units. All fire and smoke walls must be identified;

(d) The elevation of each facade;

(e) The typical sections throughout the building;

(f) The schedule of finishes;

(g) The schedule of doors and windows including the location of all exits on each level of the TBI residential home;

(h) Roof plans;

(i) Details and dimensions of elevator shaft(s), car platform(s), doors, pit(s), equipment in the machine room, and the rates of car travel must be indicated for elevators;

(j) Code analysis;

(k) The location of wheelchair ramps, if applicable; and

(l) The location of fire extinguishers and smoke alarms.

(12) Structural drawings shall include, where applicable:

(a) Plans of foundations, floors, roofs and intermediate levels which show a complete design with sizes, sections and the relative location of the various members;

(b) Schedules of beams, girders and columns; and

(c) Design live load values for wind, roof, floor, stairs, guard, handrails, and seismic.

(13) Mechanical drawings shall include, where applicable:

(a) Specifications which show the complete heating, ventilating, fire protection, medical gas systems and air conditioning systems;

(b) Water supply, sewerage and HVAC piping systems;

(c) Pressure relationships shall be shown on all floor plans;

(d) Heating, ventilating, HVAC piping, medical gas systems and air conditioning systems with all related piping and auxiliaries to provide a satisfactory installation;

(e) Water supply, sewage and drainage with all lines, risers, catch basins, manholes and cleanouts clearly indicated as to location, size, capacities, etc., and location and dimensions of septic tank and disposal field; and

(f) Color coding to show clearly supply, return and exhaust systems.

(14) Electrical drawings shall include, where applicable:

(a) A Seal certifying that all electrical work and equipment is in compliance with all applicable codes and that all materials are currently listed by recognized testing laboratories;

(b) All electrical wiring, outlets, riser diagrams, switches, special electrical connections, electrical service entrance with service switches, service feeders and characteristics of the light and power current, *and transformers when located within the building;*

(c) The electrical system shall comply with applicable codes, and shall include:

1. The fire alarm system; and

2. The emergency power system including automatic services as defined by the codes.

(d) Color coding to show all items on emergency power.

(15) Sprinkler drawings shall include, where applicable:

(a) Shop drawings, hydraulic calculations, and manufacturer cut sheets;

(b) Site plan showing elevation of fire hydrant to building, test hydrant, and flow data (Data from within a 12 month period); and

(c) Show "Point of Service" where water is used exclusively for fire protection purposes.

(16) The licensed contractor shall not install a system of water supply, plumbing, sewage, garbage or refuse disposal nor materially alter or extend any existing system until the architect or engineer submits complete plans and specifications for the installation, alteration or extension, to the Department of Health demonstrating that all applicable codes have been met and the Department has granted necessary approval.

(a) Before the TBI residential home is used, the Tennessee Department of Environment and Conservation shall approve the water supply system.

(b) Sewage shall be discharged into a municipal system or approved package system where available; otherwise, the sewage shall be treated and disposed of in a manner of operation approved by the Department of Environment and Conservation and shall comply with existing codes, ordinances and regulations which are enforced by cities, counties or other areas of local political jurisdiction.

(c) Water distribution systems shall be arranged to provide hot water at each hot water outlet at all times. Hot water at shower, bathing and hand washing facilities shall be between 105° F and 115° F.

(17) The licensed contractor shall ensure, through the submission of plans and specifications, that in each TBI residential home a negative air pressure shall be maintained in the soiled utility areas, toilet rooms, janitor's closets, dishwashing and other such soiled spaces, and a positive air pressure shall be maintained in all clean areas including, but not limited to, clean linen rooms and clean utility rooms.

(18) With the submission of plans, the TBI residential home shall specify the evacuation capabilities of the residents as defined in the National Fire Protection Association Code (NFPA). This declaration will determine the design and construction requirements of the home.

(19) The Department of Health shall acknowledge that it has reviewed plans and specifications in writing with copies sent to the project architect, the project engineer, the owner, the manager or other executive of the institution. The Department may modify the distribution of such review at its discretion.

(20) In the event submitted materials do not appear to satisfactorily comply with Rule 1200-08-37-.11 (3), the Department of Health shall furnish a letter to the party submitting the plans which shall list the particular items in question and request further explanation and/or confirmation of necessary modifications.

(21) The licensed contractor shall execute all construction in accordance with the approved plans and specifications.

(22) If construction begins within one hundred eighty (180) days of the date of the Department of Health's approval, the Department's written notification of satisfactory review constitutes compliance with Rule 1200-08-37-.11(19). This approval shall in no way permit and/or authorize any omission or deviation

from the requirements of any restrictions, laws, regulations, ordinances, codes or rules of any responsible agency.

(23) Prior to final inspection, the licensed contractor shall submit a CD Rom disc, in TIF or DMG format, of the final approved plans including all shop drawings, sprinkler, calculations, hood and duct, addenda, specifications, etc., to the Department of Health.

(24) The Department of Health requires the following alarms that shall be monitored twenty-four (24) hours per day:

(a) Fire alarms; and

(b) Generators (if applicable).

(25) Manufactured Homes. If a manufactured home unit is to be used as the TBI residential home, such unit must:

(a) Be constructed after 1976;

(b) Be designed for use as a home rather than a travel trailer;

(c) Have a manufacturer's label permanently affixed on the unit evidencing that the unit meets the requirements of the Department of Housing and Urban Development (HUD). The required label shall read as follows: "As evidenced by this label no. ABC00001, the manufacturer certifies to the best of the manufacturer's knowledge and belief that this mobile home has been inspected in accordance with the requirements of the Department of Housing and Urban Development and is constructed in conformance with the Federal Mobile Home Construction and Safety Standards in effect on the date of manufacture. See date plate." If such label is not evident and the licensee believes he/she meets the required specifications, the licensee must take the necessary steps to secure and provide verification of compliance from the manufacturer.

Authority: T.C.A. §§ 68-11-202, 68-11-206, 68-11-209, 68-11-270, and 68-11-273.

1200-08-37-.12 Life Safety.

(1) The Department of Health will consider any TBI residential home that complies with the required applicable building and fire safety regulations at the time the Board adopts new codes or regulations, so long as such compliance is maintained (either with or without waivers of specific provisions), to be in compliance with the requirements of the new codes or regulations.

(2) A TBI residential home shall ensure fire protection for residents by doing at least the following:

(a) Eliminate fire hazards;

(b) Install necessary firefighting equipment;

(c) Adopt a written fire control plan;

(d) Ensure that each resident sleeping unit shall have a door that opens directly to the outside or a corridor which leads directly to an exit door and must always be capable of being unlocked by the resident;

(e) Ensure that louvers shall not be present in doors to residents' sleeping units;

(f) Keep corridors and exit doors clear of equipment, furniture and other obstacles at all times. Passage to exit doors leading to a safe area shall be clear at all times;

(g) Prohibit use of combustible finishes and furnishings;

(h) Prohibit open flame and portable space heaters;

(i) Prohibit cooking appliances other than microwave ovens in resident sleeping units;

(j) Ensure that all heaters shall be guarded and spaced to prevent ignition of combustible material and accidental burns. The guard shall not have a surface temperature greater than 120°F;

(k) Allow use of fireplaces and/or fireplace inserts only if the TBI residential home ensures that they have guards or screens which are secured in place;

(l) Inspect and clean fireplaces and chimneys annually and maintain documentation that such inspection has occurred;

(m) Ensure that there are electrically-operated smoke detectors with battery back-up power operating at all times in, at least, all resident sleeping rooms, hallways, access areas that adjoin sleeping rooms, common areas, kitchens, laundry room, and any other hazardous areas. In multi-level homes, smoke detectors must be installed at the top of stairways; and

(n) Provide and mount fire extinguishers, complying with NFPA 10, so they are accessible to all residents in each room of the TBI residential home, including basements. Extinguishers in the kitchen and laundries shall be a minimum of 2-A: 10-BC and an extinguisher with a rating of 20-A shall be adjacent to every hazardous area. The minimum travel distance shall not exceed fifty (50) feet between the extinguishers. All fire extinguishers shall be checked at least once a year by a qualified entity.

(3) A TBI residential home located more than five (5) miles from the nearest fire station or a TBI residential home constructed of materials other than wood or concrete block shall have a complete fire alarm system meeting the requirements of the National Fire Protection Association (NFPA) 72 with approved automatic reporting to the local jurisdiction providing fire protection.

(4) A TBI residential home shall conduct fire drills in accordance with the following:

(a) Fire drills shall be held for each TBI residential home work shift in each separate TBI residential home building at least quarterly;

(b) There shall be one (1) fire drill per quarter during sleeping hours;

(c) A TBI residential home shall prepare a written report documenting the evaluation of each drill that includes the action that is recommended or taken to correct any deficiencies found; and

(d) A TBI residential home shall maintain records that document and evaluate these drills for at least three (3) years.

(5) A TBI residential home shall take the following action should a fire occur:

(a) A TBI residential home shall report all fires which result in a response by the local fire department to the Department of Health within seven (7) days of its occurrence.

(b) A TBI residential home's report to the Department of Health shall contain the following:

1. Sufficient information to ascertain the nature and location of the fire;

2. Sufficient information to ascertain the probable cause of the fire; and

3. A list and description of any injuries to any person or persons as a result of the fire.

4. A TBI residential home may omit the name(s) of resident(s) and parties involved in initial reports. Should the Department later find the identities of such persons to be necessary to an investigation, the TBI residential home shall provide such information.

(6) A TBI residential home shall take the following precautions regarding electrical equipment to ensure the safety of residents:

(a) Provide lighted corridors at all times, to a minimum of one foot candle;

(b) Provide general and night lighting for each resident and equip night lighting with emergency power;

(c) Maintain all electrical equipment in good repair and safe operating condition;

(d) Ensure that electrical cords shall not run under rugs or carpets;

(e) Ensure that electrical systems shall not be overloaded;

(f) Ensure that power strips are equipped with circuit breakers; and

(g) Prohibit use of extension cords.

(7) If a TBI residential home allows residents to smoke, it shall ensure the following:

(a) Permit smoking and smoking materials only in designated areas under supervision;

(b) Provide ashtrays wherever smoking is permitted;

(c) Smoking in bed is prohibited;

(d) Written policies and procedures for smoking within the TBI residential home shall designate a room or rooms to be used exclusively for residents who smoke. The designated smoking room or rooms shall not be the dining room, the activity room, or an individual resident sleeping unit; and

(e) Post no smoking signs in areas where oxygen is used or stored.

(8) A TBI residential home shall not allow trash and other combustible waste to accumulate within and around the TBI residential home. It shall store trash in appropriate containers with tight-fitting lids. A TBI residential home shall furnish resident sleeping units with an UL approved trash container.

(9) A TBI residential home shall ensure that:

(a) The TBI residential home maintains all safety equipment in good repair and in a safe operating condition;

(b) The TBI residential home stores janitorial supplies away from the kitchen, food storage area, dining area and other resident accessible areas;

(c) The TBI residential home stores flammable liquids in approved containers and away from the home's living areas; and

(d) The TBI residential home cleans floor and dryer vents as frequently as needed to prevent accumulation of lint, soil and dirt.

(10) A TBI residential home shall post emergency telephone numbers near a telephone accessible to the residents.

(11) A TBI residential home shall maintain its physical environment in a safe, clean and sanitary manner by doing at least the following:

(a) Prohibit any condition on the TBI residential home site conducive to the harboring or breeding of insects, rodents or other vermin;

(b) Properly identify chemical substances of a poisonous nature used to control or eliminate vermin and store such substances away from food and medications;

(c) Ensure that the home shall not become overcrowded with a combination of the TBI residential home's residents and other occupants;

(d) Maintain all residents' clothing in good repair and ensure that it is suitable for the use of the resident;

(e) Maintain the home and its heating, cooling, plumbing and electrical systems in good repair and in clean condition at all times; and

(f) Maintain temperatures in resident sleeping units and common areas at no less than 65° F and no more than 85° F.

Authority: T.C.A. §§ 68-11-202, 68-11-206, 68-11-209, 68-11-270, and 68-11-273.

1200-08-37-.13 Infectious and Hazardous Waste

(1) A TBI residential home must develop, maintain and implement written policies and procedures for the definition and handling of its infectious waste. These policies and procedures must comply with the standards of this rule.

(2) The following waste shall be considered to be infectious waste:

(a) Waste contaminated by residents who are isolated due to communicable disease, as provided in the U.S. Centers for Disease Control "Guidelines for Isolation Precautions in Hospitals";

(b) Cultures and stocks of infectious agents including specimen cultures collected from medical and pathological laboratories, cultures and stocks of infectious agents from research and industrial laboratories, wastes from the production of biologicals, discarded live and attenuated vaccines, and culture dishes and devices used to transfer, inoculate, and mix cultures;

(c) Waste human blood and blood products such as serum, plasma, and other blood components;

(d) Pathological waste, such as tissues, organs, body parts, and body fluids that are removed during surgery and autopsy;

(e) All discarded sharps (e.g., hypodermic needles, syringes, Pasteur pipettes, broken glass, scalpel blades) used in resident care or which have come into contact with infectious agents during use in medical, research, or industrial laboratories; and

(f) Other waste determined to be infectious by the TBI residential home in its written policy.

(3) Infectious and hazardous waste must be segregated from other waste at the point of generation (i.e., the point at which the material becomes a waste) within the TBI residential home.

(4) Waste must be packaged in a manner that will protect waste handlers and the public from possible injury and disease that may result from exposure to the waste. Such packaging must provide for containment of the waste from the point of generation up to the point of proper treatment or disposal. Packaging must be selected and utilized for the type of waste the package will contain, how the waste will be treated and disposed, and how it will be handled and transported, prior to treatment and disposal.

(a) Contaminated sharps must be directly placed in leak proof, rigid, and puncture-resistant containers which must then be tightly sealed.

(b) Whether disposable or reusable, all containers, bags, and boxes used for containment and disposal of infectious waste must be conspicuously identified. Packages containing infectious waste which pose additional hazards (e.g., chemical, radiological) must also be conspicuously identified to clearly indicate those additional hazards.

(c) Reusable containers for infectious waste must be thoroughly sanitized each time they are emptied, unless the surfaces of the containers have been completely protected from contamination by disposable liners or other devices removed with the waste.

(d) Opaque packaging must be used for pathological waste.

(5) After packaging, waste must be handled and transported by methods ensuring containment and preservation of the integrity of the packaging, including the use of secondary containment where necessary. Plastic bags of infectious waste must be transported by hand.

(6) Waste must be stored in a manner which preserves the integrity of the packaging, inhibits rapid microbial growth and putrefaction, and minimizes the potential of exposure or access by unknowing persons.

(a) Waste must be stored in a manner and location which affords protection from animals, precipitation, wind, and direct sunlight, does not present a safety hazard, does not provide a breeding place or food source for insects or rodents, and does not create a nuisance.

(b) Pathological waste must be promptly treated, disposed of, or placed into refrigerated storage.

(7) In the event of spills, ruptured packaging, or other incidents where there is a loss of containment of waste, the TBI residential home must ensure that proper actions are immediately taken to:

(a) Isolate the area from the public and all except essential personnel;

(b) To the extent practicable, repackage all spilled waste and contaminated debris in accordance with the requirements of paragraph (4) and/or (6) of this rule;

(c) Sanitize all contaminated equipment and surfaces according to written policies and procedures which specify how this will be done appropriately; and

(d) Complete an incident report and maintain a copy on file.

(8) Except as provided otherwise in this rule, a TBI residential home must treat or dispose of infectious waste by one or more of the methods specified in this paragraph.

(a) A TBI residential home may treat infectious waste in an on-site sterilization or disinfection device, or in an incinerator or a steam sterilizer, which has been designed, constructed, operated and maintained so that infectious waste treated in such a device is rendered non-infectious and is, if applicable, authorized for that purpose pursuant to current rules of the Department of Environment and Conservation. A valid permit or other written evidence of having complied with the Tennessee Air Pollution Control Regulations shall be available for review, if required. Each sterilizing or disinfection cycle must contain appropriate indicators to assure that conditions were met for proper sterilization or disinfection of materials included in the cycle, and appropriate records kept. Proper operation of such devices must be verified at least monthly, and records of the monthly verifications shall be available for review. Waste that contains toxic chemicals that would be volatilized by steam must not be treated in steam sterilizers. Infectious waste that has been rendered to carbonized or mineralized ash shall be deemed non-infectious. Unless otherwise hazardous and subject to the hazardous waste management requirements of the current rules of the Department of Environment and Conservation, such ash shall be disposable as a (non-hazardous) solid waste under current rules of the Department of Environment and Conservation.

(b) A TBI residential home may discharge liquid or semi-liquid infectious waste to the collection sewerage system of a wastewater treatment facility which is subject to a permit pursuant to T.C.A. § 69-3-101, et seq., provided that such discharge is in accordance with any applicable terms of that permit and/or any applicable municipal sewer use requirements.

(c) Any TBI residential home accepting waste from another state must promptly notify the Department of Environment and Conservation, county, and city public health agencies, and must strictly comply with all applicable local, state and federal regulations.

(9) A TBI residential home may have waste transported off-site for storage, treatment, or disposal. Such arrangements must be detailed in a written contract, available for review. If such off-site location is located within Tennessee, the TBI residential home must ensure that it has all necessary State and local approvals, and such approvals shall be available for review. If the off-site location is within another state, the TBI residential home must notify in writing all public health agencies with jurisdiction that the location is being used for management of the TBI residential home's waste. Waste shipped off-site must be packaged in accordance with applicable federal and state requirements. Waste transported to a sanitary landfill in this state must meet the requirements of current rules of the Department of Environment and Conservation.

(10) Human anatomical remains which are transferred to a mortician for cremation or burial shall be exempt from the requirements of this rule.

(11) All garbage, trash and other non-infectious waste shall be stored and disposed of in a manner that must not permit the transmission of disease, create a nuisance, provide a breeding place for insects and rodents, or constitute a safety hazard. All containers for waste shall be water tight, constructed of easily-cleanable material, and shall be kept on elevated platforms.

Authority: T.C.A. §§ 68-11-202, 68-11-206, 68-11-209, 68-11-270, and 68-11-273.

1200-08-37-.14 Reports.

(1) The TBI residential home shall report all incidents of abuse, neglect and misappropriation of patient/resident property to the Department of Health in accordance with T.C.A. § 68-11-211.

(2) The TBI residential home shall report the following incidents in accordance with T.C.A. § 68-11-211.

(a) Strike by staff at the home;

(b) External disasters impacting the home;

(c) Disruption of any service vital to the continued safe operation of the TBI residential home or to the health and safety of its residents and personnel; and

(d) Fires at the TBI residential home that disrupt the provision of resident care services or causes harm to the residents or staff, or that are reported by the home to any entity, including but not limited to a fire department charged with preventing fires.

Authority: T.C.A. §§ 68-11-202, 68-11-209, 68-11-211, 68-11-270, and 68-11-273.

1200-08-37-.15 Resident Rights.

(1) A TBI residential home shall ensure at least the following rights for each resident and shall not require a resident to waive any of the delineated rights:

(a) To be afforded privacy in treatment and personal care;

(b) To be free from mental and physical abuse. Should this right be violated, the TBI residential home shall notify the Department of Health and the Tennessee Department of Human Services, Adult Protective Services at 1-888-277-8366;

(c) To refuse treatment. A TBI residential home must inform the resident of the consequences of that decision. The TBI residential home must report the resident's refusal and his/her reason to the resident's treating physician and it must document such in the resident's record;

(d) To have his or her file kept confidential and private. A TBI residential home shall obtain the resident's written consent or the written consent of the resident's legal representative prior to release of information except as otherwise authorized by law;

(e) To be fully informed of the Resident's Rights, of any policies and procedures governing resident conduct, of any services available in the home, and of the schedule of all fees for any and all services;

(f) To participate in drawing up the terms of the admission agreement, including, but not limited to, providing for resident's preferences for physician care, hospitalization, nursing home care, acquisition of medication, preferences for hospice and home care providers, emergency plans and funeral arrangements;

(g) To be given thirty (30) days written notice prior to transfer or discharge, except when any physician orders the transfer because the resident requires a higher level of care;

(h) To voice grievances and recommend changes in policies and services of the TBI residential home without restraint, interference, coercion, discrimination or reprisal. A TBI residential home shall inform the resident, the resident's family member, or the resident's legal representative of procedures to voice grievances and for registering complaints confidentially;

(i) To manage his or her personal financial affairs, including the right to keep and spend his or her own money. If the resident or the resident's legal representative requests assistance from the TBI residential home in managing the resident's personal financial affairs, the request must be in writing and the resident may terminate it at any time. The TBI residential home must separate such monies from the TBI residential home's operating funds and all other deposits or expenditures, submit a written accounting to the resident or the resident's legal representative at least quarterly, and immediately return the balance upon transfer or discharge. The TBI residential home shall maintain a current copy of this report in the resident's file;

(j) To be treated with consideration, respect and full recognition of his or her dignity and individuality;

(k) To be accorded privacy for sleeping and for storage space for personal belongings;

(l) To have free access to day rooms, dining and other group living or common areas at reasonable hours and to come and go from the TBI residential home, unless such access infringes upon the rights of other residents, in accordance with the resident's plan of care;

(m) To wear his or her own clothes and to keep and use his or her own toilet articles and personal possessions;

(n) To send and receive unopened mail;

(o) To associate and communicate privately with persons of his or her choice, including receiving visitors at reasonable hours;

(p) To participate, or to refuse to participate, in community activities, including cultural, educational, religious, community service, vocational and recreational activities, in accordance with the resident's plan of care;

(q) To not be required to perform services for the TBI residential home. The resident and licensee may mutually agree, in writing, that the resident may perform certain activities or services as

part of the fee for the resident's stay and/or that the resident may perform certain activities or services as a component of the resident's plan of care; and

(r) To execute, modify, or rescind a Living Will, Do-Not-Resuscitate Order or advance directive.

Authority: T.C.A. §§ 68-11-206, 68-11-207, 68-11-209, 68-11-270, and 68-11-273.

1200-08-37-.16 Policies and Procedures for Health Care Decision-Making.

(1) Pursuant to this rule, each TBI residential home shall maintain and establish policies and procedures governing the designation by a resident of a health care decision-maker for making health care decisions for a resident when the resident becomes incompetent or lacks capacity, including, but not limited to, allowing the withholding of CPR measures from individual residents. A competent resident may give an individual instruction. The instruction may be oral or written. The instruction may be limited to take effect only if a specified condition arises.

(2) A resident may execute an advance directive for health care. The advance directive may authorize an agent to make any health care decision the resident could have made while having capacity or it may limit the power of the agent, and it may include individual instructions. An advance directive that makes no limitation on the agent's authority shall authorize the agent to make any health care decision the resident could have made while having capacity.

(3) The advance directive shall be in writing, signed by the resident, and shall either be notarized or witnessed by two (2) witnesses. Both witnesses shall be competent adults, and neither of them may be the agent. At least one (1) of the witnesses shall be a person who is not related to the resident by blood, marriage, or adoption and would not be entitled to any portion of the resident's estate upon his or her death. The advance directive shall contain a clause that attests that the witnesses comply with the requirements of this paragraph.

(4) Unless otherwise specified in an advance directive, the agent's authority becomes effective only upon a determination that the resident lacks capacity, and it ceases to be effective upon a determination that the resident has recovered capacity.

(5) A TBI residential home may use the model advance directive form that meets the requirements of the Tennessee Health Care Decisions Act and has been developed and issued by the Board for Licensing Health Care Facilities.

(6) The resident's designated physician shall make a determination that a resident either lacks or has recovered capacity. The designated physician shall also have authority to make a determination that another condition exists that affects an individual instruction or the authority of an agent. To make such determinations the resident's designated physician shall be authorized to consult with such other persons as the physician may deem appropriate.

(7) An agent shall make a health care decision in accordance with the resident's individual instructions, if any, and other wishes to the extent known to the agent. Otherwise, the agent shall make the decision in accordance with the resident's best interest. In determining the resident's best interest, the agent shall consider the resident's personal values to the extent known.

(8) An advance directive may include the individual's nomination of a court-appointed guardian.

(9) A TBI residential home shall honor an advance directive that is executed outside of this state by a nonresident of this state at the time of execution if that advance directive is in compliance with the laws of Tennessee or the state of the resident's residence.

(10) No health care provider or TBI residential home shall require the execution or revocation of an advance directive as a condition for being insured for, or receiving, health care.

(11) Any living will, durable power of attorney for health care, or other instrument signed by the resident, complying with the terms of T.C.A. § 32-11-101 et seq., and a durable power of attorney for health

care complying with the terms of T.C.A. § 34-6-201 et seq., shall be given effect and interpreted in accord with those respective acts. Any advance directive that does not evidence an intent to be given effect under those acts but that complies with these regulations may be treated as an advance directive under these regulations.

(12) A resident having capacity may revoke the designation of an agent only by a signed writing or by personally informing the supervising health care provider.

(13) A resident having capacity may revoke all or part of an advance directive, other than the designation of an agent, at any time and in any manner that communicates intent to revoke.

(14) A decree of annulment, divorce, dissolution of marriage, or legal separation revokes a previous designation of a spouse as an agent unless otherwise specified in the decree or in an advance directive.

(15) An advance directive that conflicts with a previously executed advance directive revokes the earlier directive to the extent of the conflict.

(16) Surrogates.

(a) A resident may designate any individual to act as surrogate by personally informing, either orally or in writing, the supervising health care provider.

(b) A surrogate may make a health care decision for a resident if and only if:

1. The designated physician determines that the resident lacks capacity, and

2. There is not an appointed agent or guardian; or

3. The agent or guardian is not reasonably available.

(c) In the case of a resident who lacks capacity, the resident's current clinical record at the TBI residential home shall identify his or her surrogate.

(d) The resident's surrogate shall be an adult who has exhibited special care and concern for the resident, who is familiar with the resident's personal values, who is reasonably available, and who is willing to serve.

(e) Consideration may be, but need not be, given in order of descending preference for service as a surrogate to:

1. The resident's spouse, unless legally separated;

2. The resident's adult child;

3. The resident's parent;

4. The resident's adult sibling;

5. Any other adult relative of the resident; or

6. Any other adult who satisfies the requirements of Rule 1200-08-37-.16(16)(d).

(f) No person who is the subject of a protective order or other court order that directs that person to avoid contact with the resident shall be eligible to serve as the resident's surrogate.

(g) The following criteria shall be considered in the determination of the person best qualified to serve as the surrogate:

1. Whether the proposed surrogate reasonably appears to be better able to make decisions either in accordance with the resident's known wishes or best interests;

2. The proposed surrogate's regular contact with the resident prior to and during the incapacitating illness;

3. The proposed surrogate's demonstrated care and concern;

4. The proposed surrogate's availability to visit the resident during his or her illness; and

5. The proposed surrogate's availability to engage in face-to-face contact with health care providers for the purpose of fully participating in the decision-making process.

(h) If the resident lacks capacity and none of the individuals eligible to act as a surrogate under Rules 1200-08-37-.16(16)(c) thru 1200-08-37-.16(16)(g) is reasonably available, the designated physician may make health care decisions for the resident after the resident either:

1. Consults with and obtains the recommendations of a TBI residential home's ethics mechanism or standing committee in the home that evaluates health care issues; or

2. Obtains concurrence from a second physician who is not directly involved in the resident's health care, does not serve in a capacity of decision-making, influence, or responsibility over the designated physician, and is not under the designated physician's decision-making, influence, or responsibility.

(i) In the event of a challenge, there shall be a rebuttable presumption that the selection of the surrogate was valid. Any person who challenges the selection shall have the burden of proving the invalidity of that selection.

(j) A surrogate shall make a health care decision in accordance with the resident's individual instructions, if any, and other wishes to the extent known to the surrogate. Otherwise, the surrogate shall make the decision in accordance with the surrogate's determination of the resident's best interest. In determining the resident's best interest, the surrogate shall consider the resident's personal values to the extent known.

(k) A surrogate who has not been designated by the resident may make all health care decisions for the resident that the resident could make on the resident's own behalf, except that artificial nutrition and hydration may be withheld or withdrawn for a resident upon a decision of the surrogate only when the designated physician and a second independent physician certify in the resident's current clinical records that the provision or continuation of artificial nutrition or hydration is merely prolonging the act of dying and the resident is highly unlikely to regain capacity to make medical decisions.

(l) Except as provided in Rule 1200-08-37-.16(16)(m):

1. A designated surrogate may not be one of the following:

(i) the treating health care provider;

(ii) an employee of the treating health care provider;

(iii) an operator of the TBI residential home; or

(iv) an employee of an operator of the TBI residential home; and

2. A health care provider or employee of a health care provider may not act as a surrogate if the health care provider becomes the resident's treating health care provider.

(m) A designated surrogate may be an employee of the treating health care provider or an employee of an operator of the TBI residential home if:

1. The employee so designated is a relative of the resident by blood, marriage, or adoption; and

2. The other requirements of this section are satisfied.

(n) A health care provider may require an individual claiming the right to act as surrogate for a resident to provide written documentation stating facts and circumstances reasonably sufficient to establish the claimed authority.

(17) Guardian.

(a) A guardian shall comply with the resident's individual instructions and may not revoke the resident's advance directive absent a court order to the contrary.

(b) Absent a court order to the contrary, a health care decision of an agent takes precedence over that of a guardian.

(c) A health care provider may require an individual claiming the right to act as guardian for a resident to provide written documentation stating facts and circumstances reasonably sufficient to establish the claimed authority.

(18) A designated physician who makes or is informed of a determination that a resident lacks or has recovered capacity, or that another condition exists which affects an individual instruction or the authority of an agent, guardian, or surrogate, shall promptly record such a determination in the resident's current clinical record and communicate the determination to the resident, if possible, and to any person then authorized to make health care decisions for the resident.

(19) Except as provided in Rules 1200-08-37-.16(20) thru 1200-08-37-.16(22), a health care provider or TBI residential home providing care to a resident shall:

(a) Comply with an individual instruction of the resident and with a reasonable interpretation of that instruction made by a person then authorized to make health care decisions for the resident; and

(b) Comply with a health care decision for the resident made by a person then authorized to make health care decisions for the resident to the same extent as if the decision had been made by the resident while having capacity.

(20) A health care provider may decline to comply with an individual instruction or health care decision for reasons of conscience.

(21) A TBI residential home may decline to comply with an individual instruction or health care decision if the instruction or decision is:

(a) Contrary to the home's policy which is based on reasons of conscience, and

(b) The home timely communicated the policy to the resident or to a person then authorized to make health care decisions for the resident.

(22) A health care provider or TBI residential home may decline to comply with an individual instruction or health care decision that requires medically inappropriate health care or health care contrary to generally accepted health care standards applicable to the health care provider or home.

(23) A health care provider or TBI residential home that declines to comply with an individual instruction or health care decision pursuant to Rule 1200-08-37-.16(20) thru 1200-08-37-.16(22) shall:

(a) Promptly inform the resident, if possible, and/or any other person then authorized to make health care decisions for the resident;

(b) Provide continuing care to the resident until he can be transferred to another health care provider or institution or it is determined that such a transfer is not possible;

(c) Immediately make all reasonable efforts to assist in the transfer of the resident to another health care provider or institution that is willing to comply with the instruction or decision unless the resident or person then authorized to make health care decisions for the resident refuses assistance; and

(d) If a transfer cannot be effected, the health care provider or TBI residential home shall not be compelled to comply.

(24) Unless otherwise specified in an advance directive, a person then authorized to make health care decisions for a resident has the same rights as the resident to request, receive, examine, copy, and consent to the disclosure of medical or any other health care information.

(25) A health care provider or TBI residential home acting in good faith and in accordance with generally accepted health care standards applicable to the health care provider or home is not subject to civil or criminal liability or to discipline for unprofessional conduct for:

(a) Complying with a health care decision of a person apparently having authority to make a health care decision for a resident, including a decision to withhold or withdraw health care;

(b) Declining to comply with a health care decision of a person based on a belief that the person then lacked authority; or

(c) Complying with an advance directive and assuming that the directive was valid when made and had not been revoked or terminated.

(26) An individual acting as an agent or surrogate is not subject to civil or criminal liability or to discipline for unprofessional conduct for health care decisions made in good faith.

(27) A person identifying a surrogate is not subject to civil or criminal liability or to discipline for unprofessional conduct if such identification is made in good faith.

(28) A copy of a written advance directive, revocation of an advance directive, or designation or disqualification of a surrogate has the same effect as the original.

(29) The withholding or withdrawal of medical care from a resident in accordance with the provisions of the Tennessee Health Care Decisions Act shall not, for any purpose, constitute a suicide, euthanasia, homicide, mercy killing, or assisted suicide.

(30) Physician orders for scope of treatment (POST)

(a) Physician orders for scope of treatment (POST) may be issued by a physician for a patient with whom the physician has a bona fide physician-patient relationship, but only:

1. With the informed consent of the patient;

2. If the patient is a minor or is otherwise incapable of making an informed decision regarding consent for such an order, upon request of and with the consent of the agent, surrogate, or other person authorized to consent on the patient's behalf under the Tennessee Health Care Decisions Act; or

3. If the patient is a minor or is otherwise incapable of making an informed decision regarding consent for such an order and the agent, surrogate, or other person authorized to consent on the patient's behalf under the Tennessee Health Care Decisions Act, is not

reasonably available, if the physician determines that the provision of cardiopulmonary resuscitation would be contrary to accepted medical standards.

(b) A POST may be issued by a physician assistant, nurse practitioner or clinical nurse specialist for a patient with whom such physician assistant, nurse practitioner or clinical nurse specialist has a bona fide physician assistant-patient or nurse-patient relationship, but only if:

1. No physician, who has a bona fide physician-patient relationship with the patient, is present and available for discussion with the patient (or if the patient is a minor or is otherwise incapable of making an informed decision, with the agent, surrogate, or other person authorized to consent on the patient's behalf under the Tennessee Health Care Decisions Act);

2. Such authority to issue is contained in the physician assistant's, nurse practitioner's or clinical nurse specialist's protocols;

3. Either:

   (i) The patient is a resident of a nursing home licensed under title 68 or an ICF/MR facility licensed under title 33 and is in the process of being discharged from the nursing home or transferred to another facility at the time the POST is being issued; or

   (ii) The patient is a hospital patient and is in the process of being discharged from the hospital or transferred to another facility at the time the POST is being issued; and

4. Either:

   (i) With the informed consent of the patient;

   (ii) If the patient is a minor or is otherwise incapable of making an informed decision regarding consent for such an order, upon request of and with the consent of the agent, surrogate, or other person authorized to consent on the patient's behalf under the Tennessee Health Care Decisions Act; or

   (iii) If the patient is a minor or is otherwise incapable of making an informed decision regarding consent for such an order and the agent, surrogate, or other person authorized to consent on the patient's behalf under the Tennessee Health Care Decisions Act, is not reasonably available and such authority to issue is contained in the physician assistant, nurse practitioner or clinical nurse specialist's protocols and the physician assistant or nurse determines that the provision of cardiopulmonary resuscitation would be contrary to accepted medical standards.

(c) If the patient is an adult who is capable of making an informed decision, the patient's expression of the desire to be resuscitated in the event of cardiac or respiratory arrest shall revoke any contrary order in the POST. If the patient is a minor or is otherwise incapable of making an informed decision, the expression of the desire that the patient be resuscitated by the person authorized to consent on the patient's behalf shall revoke any contrary order in the POST. Nothing in this section shall be construed to require cardiopulmonary resuscitation of a patient for whom the physician or physician assistant or nurse practitioner or clinical nurse specialist determines cardiopulmonary resuscitation is not medically appropriate.

(d) A POST issued in accordance with this section shall remain valid and in effect until revoked. In accordance with this rule and applicable regulations, qualified emergency medical services personnel; and licensed health care practitioners in any facility, program, or organization operated or licensed by the Board for Licensing Health Care Facilities, the Department of Mental Health and Substance Abuse Services, or the Department of Intellectual and Developmental Disabilities, or operated, licensed, or owned by another state agency, shall

follow a POST that is available to such persons in a form approved by the Board for Licensing Health Care Facilities.

(e) Nothing in these rules shall authorize the withholding of other medical interventions, such as medications, positioning, wound care, oxygen, suction, treatment of airway obstruction or other therapies deemed necessary to provide comfort care or alleviate pain.

(f) If a person has a do-not-resuscitate order in effect at the time of such person's discharge from a health care facility, the facility shall complete a POST prior to discharge. If a person with a POST is transferred from one health care facility to another health care facility, the health care facility initiating the transfer shall communicate the existence of the POST to qualified emergency medical service personnel and to the receiving facility prior to the transfer. The transferring facility shall provide a copy of the POST that accompanies the patient in transport to the receiving health care facility. Upon admission, the receiving facility shall make the POST a part of the patient's record.

(g) These rules shall not prevent, prohibit, or limit a physician from using a written order, other than a POST, not to resuscitate a patient in the event of cardiac or respiratory arrest in accordance with accepted medical practices. This action shall have no application to any do not resuscitate order that is not a POST, as defined in these rules.

(h) Valid do not resuscitate orders or emergency medical services do not resuscitate orders issued before July 1, 2004, pursuant to then-current law, shall remain valid and shall be given effect as provided in these rules.

Authority: T.C.A. §§ 68-11-209, 68-11-224, and 68-11-1801, et seq.

1200-08-37-.17 Disaster Preparedness.

(1) A TBI residential home shall have in effect and available for all supervisory personnel and staff written copies of the following disaster, refuge and/or evacuation plans readily available at all times:

(a) Fire Safety Procedures Plan shall include:

1. Minor fires;

2. Major fires;

3. Fighting the fire;

4. Evacuation procedures; and

5. Staff functions.

(b) Tornado/Severe Weather Procedures Plan shall include:

1. Staff duties and

2. Evacuation procedures.

(c) Bomb Threat Procedures Plan shall include:

1. Staff duties;

2. Search team, searching the premises;

3. Notification of authorities;

4. Location of suspicious objects; and

5. Evacuation procedures.

(d) Flood Procedure Plan, if applicable, shall include:

1. Staff duties;

2. Evacuation procedures; and

3. Safety procedures following the flood.

(e) Severe Cold Weather and Severe Hot Weather Procedure Plans shall include:

1. Staff duties;

2. Equipment failures;

3. Evacuation procedures; and

4. Emergency food service.

(f) Earthquake Disaster Procedures Plan shall include:

1. Staff duties;

2. Evacuation procedures;

3. Safety procedures; and

4. Emergency services.

(2) A TBI residential home shall comply with the following:

(a) Maintain a detailed log with staff signatures designating the training each employee receives regarding disaster preparedness.

(b) Train all employees annually as required in the plans listed above and keep each employee informed with respect to the employee's duties under the plans.

(c) Exercise each of the plans listed above annually.

(3) A TBI residential home shall participate in the Tennessee Emergency Management Agency local/county emergency plan on an annual basis. Participation includes:

(a) Filling out and submitting a questionnaire on a form to be provided by the Tennessee Emergency Management Agency; and

(b) Maintaining documentation of participation that shall be made available to survey staff as proof of participation.

(4) A TBI residential home shall have a functioning emergency back-up generator adequate to meet the TBI residential home's HVAC and essential needs until regular service is restored. The TBI residential home shall have a minimum of twenty-four (24) hours of fuel designed to operate at its rated load. This requirement shall be coordinated with the Disaster Preparedness Plan or with the local resources.

(a) All generators shall be exercised for thirty (30) minutes each month under full load, including automatic and manual transfer of equipment.

(b) The emergency generator shall be operated at the existing connected load and not on dual power. The TBI residential home shall maintain a monthly log and have trained staff familiar with the generator's operation.

Authority: T.C.A. §§ 68-11-202, 68-11-206, 68-11-209, 68-11-270, and 68-11-273.

1200-08-37-.18 Appendix I.

(1) Physician Orders for Scope of Treatment (POST) Form

A COPY OF THIS FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

Tennessee Physician Orders for Scope of Treatment (POST, sometimes called "POLST") This is a Physician Order Sheet based on the medical conditions and wishes of the person identified at right ("patient"). Any section not completed indicates full treatment for that section. When need occurs, first follow these orders, then contact physician.	Patient's Last Name First Name/Middle Initial Date of Birth

Section A *Check One Box Only*

CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse and is not breathing.

☐ **Resuscitate(CPR)** ☐ **Do Not Attempt Resuscitation (DNR / no CPR) (Allow Natural Death)**

When not in cardiopulmonary arrest, follow orders in **B, C,** and **D.**

Section B *Check One Box Only*

MEDICAL INTERVENTIONS. Patient has pulse and/or is breathing.

☐ **Comfort Measures Only.** Relieve pain and suffering through the use of any medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. **Do not transfer to hospital for life-sustaining treatment. Transfer only if comfort needs cannot be met in current location. Treatment Plan: Maximize comfort through symptom management.**

☐ **Limited Additional Interventions.** In addition to care described in Comfort Measures Only above, use medical treatment, antibiotics, IV fluids and cardiac monitoring as indicated. No intubation, advanced airway interventions, or mechanical ventilation. May consider less invasive airway support (e.g. CPAP, BiPAP). **Transfer** to hospital if indicated. Generally avoid the intensive care unit. **Treatment Plan: basic medical treatments.**

☐ **Full Treatment.** In addition to care described in Comfort Measures Only and Limited Additional Interventions above, use intubation, advanced airway interventions, and mechanical ventilation as indicated. **Transfer** to hospital and/or intensive care unit if indicated. **Treatment Plan: Full treatment including in the intensive care unit.**

*Other Instructions:*_____

Section C *Check One*

ARTIFICIALLY ADMINISTERED NUTRITION. Oral fluids & nutrition must be offered if feasible.

☐ No artificial nutrition by tube.
☐ Defined trial period of artificial nutrition by tube.
☐ Long-term artificial nutrition by tube.

*Other Instructions:*_____

Section D *Must be Completed*

Discussed with:	**The Basis for These Orders Is:** (Must be completed)
☐ Patient/Resident ☐ Health care agent ☐ Court-appointed guardian ☐ Health care surrogate ☐ Parent of minor ☐ Other: _____(Specify)	☐ Patient's preferences ☐ Patient's best interest (patient lacks capacity or preferences unknown) ☐ Medical indications ☐ (Other) _____

Physician/NP/CNS/PA Name (Print)	**Physician/NP/CNS/PA Signature Date** NP/CNS/PA (Signature at Discharge)	**MD/NP/CNS/PA Phone Number:**

Signature of Patient, Parent of Minor, or Guardian/Health Care Representative			
Preferences have been expressed to a physician and/or health care professional. It can be reviewed and updated at any time if your preferences change. If you are unable to make your own health care decisions, the orders should reflect your preferences as best understood by your surrogate.			
Name (print)	Signature	Relationship (write "self" if patient)	
Agent/Surrogate	Relationship	Phone Number	
Health Care Professional Preparing Form	Preparer Title	Phone Number	Date Prepared

HIPAA PERMITS DISCLOSURE OF POST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

Directions for Health Care Professionals

Completing POST

Must be completed by a health care professional based on patient preferences, patient best interest, and medical indications.

To be valid, POST must be signed by a physician or, at discharge or transfer from a hospital or long term care facility, by a nurse practitioner (NP), clinical nurse specialist (CNS), or physician assistant (PA). Verbal orders are acceptable with follow-up signature by physician in accordance with facility/community policy.

Persons with DNR in effect at time of discharge must have POST completed by health care facility prior to discharge and copy of POST provided to qualified medical emergency personnel.

Photocopies/faxes of signed POST forms are legal and valid.

Using POST

Any incomplete section of POST implies full treatment for that section.

No defibrillator (including AEDs) should be used on a person who has chosen "Do Not Attempt Resuscitation".

Oral fluids and nutrition must always be offered if medically feasible.

When comfort cannot be achieved in the current setting, the person, including someone with "Comfort Measures Only", should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).

IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort Measures Only".

Treatment of dehydration is a measure which prolongs life. A person who desires IV fluids should indicate "Limited Interventions" or "Full Treatment".

A person with capacity, or the Health Care Agent or Surrogate of a person without capacity, can request alternative treatment.

Reviewing POST

This POST should be reviewed if:

(1) The patient is transferred from one care setting or care level to another, or
(2) There is a substantial change in the patient's health status, or
(3) The patient's treatment preferences change.

Draw line through sections A through D and write "VOID" in large letters if POST is replaced or becomes invalid.

COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED.

DO NOT ALTER THIS FORM

(2) Advance Care Plan Form

ADVANCE CARE PLAN
(Tennessee)

I, _____, hereby give these advance instructions on how I want to be treated by my doctors and other health care providers when I can no longer make those treatment decisions myself.

Agent: I want the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: _____ Phone #: _____ Relation:_____
Address: _____

Alternate Agent: If the person named above is unable or unwilling to make health care decisions for me, I appoint as alternate the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: _____ Phone #: _____ Relation: _____
Address: _____

My agent is also my personal representative for purposes of federal and state privacy laws, including HIPAA.

When Effective (mark one): ☐ I give my agent permission to make health care decisions for me at any time, even if I have capacity to make decisions for myself. ☐ I do not give such permission (this form applies only when I no longer have capacity).

Quality of Life: By marking "yes" below, I have indicated conditions I would be willing to live with if given adequate comfort care and pain management. By marking "**no**" below, I have indicated conditions I would not be willing to live with (that to me would create an **unacceptable** quality of life).

☐ Yes ☐ No	**Permanent Unconscious Condition:** I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
☐ Yes ☐ No	**Permanent Confusion:** I become unable to remember, understand, or make decisions. I do not recognize loved ones or cannot have a clear conversation with them.
☐ Yes ☐ No	**Dependent in all Activities of Daily Living:** I am no longer able to talk or communicate clearly or move by myself. I depend on others for feeding, bathing, dressing, and walking. Rehabilitation or any other restorative treatment will not help.
☐ Yes ☐ No	**End-Stage Illnesses:** I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that no longer responds to treatment; chronic and/or damaged heart and lungs, where oxygen is needed most of the time and activities are limited due to the feeling of suffocation.

Treatment: If my quality of life becomes unacceptable to me (as indicated by one or more of the conditions marked "no" above) and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. By marking "yes" below, I have indicated treatment I want. By marking "**no**" below, I have indicated treatment I **do not want**.

☐ Yes	☐ No	**CPR (Cardiopulmonary Resuscitation):** To make the heart beat again and restore breathing after it has stopped. Usually this involves electric shock, chest compressions, and breathing assistance.
☐ Yes	☐ No	**Life Support / Other Artificial Support:** Continuous use of breathing machine, IV fluids, medications, and other equipment that helps the lungs, heart, kidneys, and other organs to continue to work.
☐ Yes	☐ No	**Treatment of New Conditions:** Use of surgery, blood transfusions, or antibiotics that will deal with a new condition but will not help the main illness.
☐ Yes	☐ No	**Tube feeding/IV fluids:** Use of tubes to deliver food and water to a patient's stomach or use of IV fluids into a vein, which would include artificially delivered nutrition and hydration.

Please sign on page 2

Other instructions, such as burial arrangements, hospice care, etc.: _____

(Attach additional pages if necessary)

Organ donation: Upon my death, I wish to make the following anatomical gift (mark one):

☐ Any organ/tissue ☐ My entire body ☐ Only the following organs/tissues: _____

☐ No organ/tissue donation.

SIGNATURE

Your signature must **either** be witnessed by two competent adults **or** notarized. If witnessed, neither witness may be the person you appointed as your agent or alternate, and at least one of the witnesses must be someone who is not related to you or entitled to any part of your estate.

Signature: _____ Date: _____
(Patient)

Witnesses:

1. I am a competent adult who is not named as the agent or alternate. I witnessed the patient's signature on this form.

_____
Signature of witness number 1

2. I am a competent adult who is not named as the agent or alternate. I am not related to the patient by blood, marriage, or adoption and I would not be entitled to any portion of the patient's estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the patient's signature on this form.

_____
Signature of witness number 2

This document may be notarized instead of witnessed:

STATE OF TENNESSEE
COUNTY OF _____

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person who signed as the "patient." The patient personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

My commission expires: _____ _____
Signature of Notary Public

WHAT TO DO WITH THIS ADVANCE DIRECTIVE

- Provide a copy to your physician(s)
- Keep a copy in your personal files where it is accessible to others
- Tell your closest relatives and friends what is in the document
- Provide a copy to the person(s) you named as your health care agent

Authority: T.C.A. §§ 68-11-209, 68-11-224, and 68-11-1801, et seq.

* If a roll-call vote was necessary, the vote by the Agency on these rulemaking hearing rules was as follows:

Board Member	Aye	No	Abstain	Absent	Signature (if required)
Carissa S. Lynch				X	
Michael Miller				X	
Janice M. Hill	X				
Robert Gordon	X				
John A. Marshall	X				
Jennifer Gordon-Maloney				X	
Roy King				X	
Annette Marlar	X				
Robert C. Breeden	X				
Sylvia Burton	X				
Betsy Cummins	X				
David Rhodes	X				
Joshua A. Crisp	X				
Betty S. Hodge				X	
Bobby Wood	X				
Larry Arnold, M.D.				X	
Jim Shulman	X				

I certify that this is an accurate and complete copy of rulemaking hearing rules, lawfully promulgated and adopted by the Board for Licensing Health Care Facilities (board/commission/ other authority) on 01/23/2014 (mm/dd/yyyy), and is in compliance with the provisions of T.C.A. § 4-5-222.

I further certify the following:

Notice of Rulemaking Hearing filed with the Department of State on: *10/01/13 (mm/dd/yy)*

Rulemaking Hearing(s) Conducted on: (add more dates). *01/23/14 (mm/dd/yy)*

Date: 10-1-2015

Signature:

Name of Officer: Devin M. Wells

Title of Officer: Deputy General Counsel, Department of Health

Subscribed and sworn to before me on: 10/1/15

Notary Public Signature:

My commission expires on: MY COMMISSION EXPIRES APRIL 19, 2017

SUZANNE MECHKOWSKI NOTARY PUBLIC STATE OF TENNESSEE SUMNER COUNTY

Board for Licensing Health Care Facilities Rules
Rule Chapter 1200-08-37
Traumatic Brain Injury Residential Homes
New Rule Chapter

All rulemaking hearing rules provided for herein have been examined by the Attorney General and Reporter of the State of Tennessee and are approved as to legality pursuant to the provisions of the Administrative Procedures Act, Tennessee Code Annotated, Title 4, Chapter 5.

Herbert H. Slatery III
Herbert H. Slatery III
Attorney General and Reporter

10-27-15
Date

Department of State Use Only

Filed with the Department of State on: 10-28-15

Effective on: 1-26-16

Tre Hargett
Secretary of State

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PUBLICATIONS

G.O.C. STAFF RULE ABSTRACT

BOARD:	Board for Licensing Health Care Facilities
SUBJECTS:	Standards for Ambulatory Surgical Treatment Centers; Standards for Outpatient Diagnostic Centers
STATUTORY AUTHORITY:	42 Code of Federal Regulations Chapter IV, and Parts 482 and 485
EFFECTIVE DATES:	January 18, 2016 through June 30, 2016
FISCAL IMPACT:	According to the Department, the state funds necessary to implement the rule were appropriated by the General Assembly.
STAFF RULE ABSTRACT:	The rulemaking hearing rules specify that patients at ambulatory surgical treatment centers are not required to sign advance directive and organ donation forms. The Board states that this change clarifies that any such forms must only be included in a patient's chart if the forms are available. The rules also limit the present requirement that a qualified registered nurse is present during and following invasive diagnostic procedures performed at outpatient diagnostic centers to situations where anything greater than local anesthesia is used during the procedure.

Public Hearing Comments

One copy of a document containing responses to comments made at the public hearing must accompany the filing pursuant to T.C.A. § 4-5-222. Agencies shall include only their responses to public hearing comments, which can be summarized. No letters of inquiry from parties questioning the rule will be accepted. When no comments are received at the public hearing, the agency need only draft a memorandum stating such and include it with the Rulemaking Hearing Rule filing. Minutes of the meeting will not be accepted. Transcripts are not acceptable.

There were no comments, either written or oral.

Regulatory Flexibility Addendum
Pursuant to T.C.A. §§ 4-5-401 through 4-5-404, prior to initiating the rule making process as described in T.C.A. § 4-5-202(a)(3) and T.C.A. § 4-5-202(a), all agencies shall conduct a review of whether a proposed rule or rule affects small businesses.

REGULATORY FLEXIBILITY ANALYSIS

(1) **The extent to which the rule or rule may overlap, duplicate, or conflict with other federal, state, and local governmental rules.**

These rules do not overlap, duplicate, or conflict with other federal, state, or local governmental rules.

(2) **Clarity, conciseness, and lack of ambiguity in the rule or rules.**

These rules exhibit clarity, conciseness, and lack of ambiguity.

(3) **The establishment of flexible compliance and/or reporting requirements for small businesses.**

These rules do not create flexible compliance and/or reporting requirements for small businesses.

(4) **The establishment of friendly schedules or deadlines for compliance and/or reporting requirements for small businesses.**

These rules do not involve schedules or deadlines for compliance or reporting requirements for small businesses.

(5) **The consolidation or simplification of compliance or reporting requirements for small businesses.**

These rules do not consolidate or simplify compliance reporting requirements for small businesses.

(6) **The establishment of performance standards for small businesses as opposed to design or operational standards required in the proposed rule.**

These rules do not establish performance, design, or operational standards.

(7) **The unnecessary creation of entry barriers or other effects that stifle entrepreneurial activity, curb innovation, or increase costs.**

These rules do not create unnecessary barriers or stifle entrepreneurial activity or innovation.

STATEMENT OF ECONOMIC IMPACT TO SMALL BUSINESSES

Name of Board, Committee or Council: Board for Licensing Health Care Facilities

Rulemaking hearing date: January 21, 2015

1. **Type or types of small business and an identification and estimate of the number of small businesses subject to the proposed rule that would bear the cost of, and/or directly benefit from the proposed rule:**

   Surgical Ambulatory Treatment Centers and Outpatient Diagnostic Centers and those surgeons offering non-invasive procedures within these facilities will benefit from the proposed rule amendments. Currently, there are one hundred and sixty (160) Surgical Ambulatory Treatment Centers and forty (40) Outpatient Diagnostic Centers.

2. **Projected reporting, recordkeeping and other administrative costs required for compliance with the proposed rule, including the type of professional skills necessary for preparation of the report or record:**

   There are no reporting, recordkeeping and other administrative costs required for compliance with the proposed rule.

3. **Statement of the probable effect on impacted small businesses and consumers:**

   Small businesses will be positively affected by the proposed rule amendments as the new rule will limit the qualified nurse requirement to those surgeries involving invasive procedures and using sedation methods greater than local anesthesia. Under the current rule, surgeons performing non-invasive procedures in ASTCs and Outpatient Diagnostic Centers, as well as the facilities themselves, are receiving citations for not having qualified nurses in the operating rooms; thereby, creating an unnecessary negative economic impact.

4. **Description of any less burdensome, less intrusive or less costly alternative methods of achieving the purpose and/or objectives of the proposed rule that may exist, and to what extent, such alternative means might be less burdensome to small business:**

   There are no less burdensome, less intrusive or less costly alternative methods of achieving the purpose of the proposed rule amendments.

5. **Comparison of the proposed rule with any federal or state counterparts:**

   Federal: CMS-9070-F does not contain a list for equipment required in the facility; rather, the rule contains language requiring the facility to develop its own policies and procedures specifying which types of equipment they deem appropriate.

   State: None.

6. **Analysis of the effect of the possible exemption of small businesses from all or any part of the requirements contained in the proposed rule.**

   These rules do not provide for any exemptions for small businesses.

Impact on Local Governments

Pursuant to T.C.A. §§ 4-5-220 and 4-5-228 "any rule proposed to be promulgated shall state in a simple declarative sentence, without additional comments on the merits of the policy of the rules or regulation, whether the rule or regulation may have a projected impact on local governments." (See Public Chapter Number 1070 (http://state.tn.us/sos/acts/106/pub/pc1070.pdf) of the 2010 Session of the General Assembly)

The proposed rule amendments should not have a financial impact on local governments.

Department of State
Division of Publications
312 Rosa L. Parks Avenue, 8th Floor Snodgrass/TN Tower
Nashville, TN 37243
Phone: 615-741-2650
Email: publications.information@tn.gov

For Department of State Use Only

Sequence Number: 10-15-15
Rule ID(s): 6660, 6661
File Date: 10-20-15
Effective Date: 1-18-16

Rulemaking Hearing Rule(s) Filing Form

Rulemaking Hearing Rules are rules filed after and as a result of a rulemaking hearing (Tenn. Code Ann. § 4-5-205).

Pursuant to Tenn. Code Ann. § 4-5-229, any new fee or fee increase promulgated by state agency rule shall take effect on July 1, following the expiration of the ninety (90) day period as provided in § 4-5-207. This section shall not apply to rules that implement new fees or fee increases that are promulgated as emergency rules pursuant to § 4-5-208(a) and to subsequent rules that make permanent such emergency rules, as amended during the rulemaking process. In addition, this section shall not apply to state agencies that did not, during the preceding two (2) fiscal years, collect fees in an amount sufficient to pay the cost of operating the board, commission or entity in accordance with § 4-29-121(b).

Agency/Board/Commission:	Department of Health
Division:	Board for Licensing Health Care Facilities
Contact Person:	Devin M. Wells Deputy General Counsel
Address:	665 Mainstream Drive, Nashville, Tennessee
Zip:	37243
Phone:	(615) 741-1611
Email:	Devin.M.Wells@tn.gov

Revision Type (check all that apply):
X Amendment
___ New
___ Repeal

Rule(s) Revised (**ALL** chapters and rules contained in filing must be listed here. If needed, copy and paste additional tables to accommodate multiple chapters. Please enter only **ONE** Rule Number/Rule Title per row)

Chapter Number	**Chapter Title**
1200-08-10	Standards for Ambulatory Surgical Treatment Centers
Rule Number	**Rule Title**
1200-08-10-.06	Basic Services

Chapter Number	**Chapter Title**
1200-08-35	Standards for Outpatient Diagnostic Centers
Rule Number	**Rule Title**
1200-08-35-.06	Basic Services

(Rule 1200-08-10-.05, continued)

(8) The ASTC shall have available a plan for emergency transportation to a licensed local hospital.

(9) The facility must ensure continuity of care and provide an effective discharge planning process that applies to all patients. The facility's discharge planning process, including discharge policies and procedures, must be specified in writing and must:

(a) Be developed and/or supervised by a registered nurse, social worker or other appropriately qualified personnel;

(b) Begin upon admission;

(c) Be provided when identified as a need by the patient, a person acting on the patient's behalf, or by the physician; and

(d) Include the likelihood of a patient's capacity for self-care or the possibility of the patient returning to his or her pre-ambulatory surgical treatment center environment.

(10) A discharge plan is required on every patient, even if the discharge is to home.

(11) The facility must arrange for the initial implementation of the patient's discharge plan and must reassess the patient's discharge plan if there are factors that may affect continuing care needs or the appropriateness of the discharge plan.

(12) As needed, the patient and family members or interested persons must be taught and/or counseled to prepare them for post-operative care.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-209, and 68-11-216.* ***Administrative History:*** *Original rule filed July 22, 1977; effective August 22, 1977. Repeal and new rule filed June 30, 1992; effective August 14, 1992. Repeal and new rule filed March 21, 2000; effective June 4, 2000. Amendment filed June 16, 2003; effective August 30, 2003.*

1200-08-10-.06 BASIC SERVICES.

(1) Surgical Services.

(a) Facilities restricted in services they provide, e.g. those that restrict services to radiation therapy or use of local anesthetics only, may be exempted from all or part of the requirements of this rule pertaining to laboratory services, food and dietetic services, surgical services, and anesthesia services.

(b) If the facility provides surgical services, the services must be well organized and provided in accordance with acceptable standards of practice. If outpatient surgical services are offered, the services must be consistent in quality with inpatient care in accordance with the complexity of services offered.

(c) A hospital may choose to separately license a portion of the facility as an Ambulatory Surgical Treatment Center; the licensure fee for such is not required.

(d) The organization of the surgical services must be appropriate to the scope of the services offered.

(e) The operating rooms must be supervised by an experienced registered nurse or a doctor of medicine or osteopathy.

(Rule 1200-08-10-.06, continued)

(f) An ASTC may use scrub nurses in its operating rooms. For the purposes of this rule, a "scrub nurse" is defined as a registered nurse or either a licensed practical nurse (L.P.N.) or a surgical technologist (operating room technician) supervised by a registered nurse who works directly with a surgeon within the sterile field, passing instruments, sponges, and other items needed during the procedure and who scrubs his or her hands and arms with special disinfecting soap and wears surgical gowns, caps, eyewear, and gloves, when appropriate.

(g) Qualified registered nurses may perform circulating duties in the operating room. In accordance with applicable State laws and approved medical staff policies and procedures, LPNs and surgical technologists may assist in circulatory duties under the supervision of a qualified registered nurse who is immediately available to respond to emergencies.

(h) Surgical privileges must be delineated for all practitioners performing surgery in accordance with the competencies of each practitioner. The surgical service must maintain a roster of practitioners specifying the surgical privileges of each practitioner.

(i) Surgical services must be consistent with needs and resources. Policies covering surgical care must be designed to assure the achievement and maintenance of high standards of medical practice and patient care.

(j) Surgical technologists must:

1. Hold current national certification established by the Liaison Council on Certification for the Surgical Technologist (LCC-ST); or

2. Have completed a program for surgical technology accredited by the Commission on Accreditation of Allied Health Education Programs (CAAHEP); or

3. Have completed an appropriate training program for surgical technologists in the armed forces or at a CAAHEP accredited hospital or CAAHEP accredited ambulatory surgical treatment center; or

4. Successfully complete the surgical technologists LCC-ST certifying exam; or

5. Provide sufficient evidence that, prior to May 21, 2007, the person was at any time employed as a surgical technologist for not less than eighteen (18) months in the three (3) years preceding May 21, 2007 in a hospital, medical office, surgery center, or an accredited school of surgical technology; or has begun the appropriate training to be a surgical technologist prior to May 21, 2007, provided that such training is completed within three (3) years of May 21, 2007.

(k) An ASTC can petition the director of health care facilities of the department for a waiver from the provisions of 1200-08-10-.06(1)(j) if they are unable to employ a sufficient number of surgical technologists who meet the requirements. The facility shall demonstrate to the director that a diligent and thorough effort has been made to employ surgical technologist who meet the requirements. The director shall refuse to grant a waiver upon finding that a diligent and thorough effort has not been made. A waiver shall exempt a facility from meeting the requirements for not more than nine (9) months. Additional waivers may be granted, but all exemptions greater than twelve (12) months shall be approved by the Board for Licensing Health Care Facilities.

(l) Surgical technologists shall demonstrate continued competence in order to perform their professional duties in surgical technology. The employer shall maintain evidence

(Rule 1200-08-10-.06, continued)

of the continued competence of such individuals. Continued competence activities may include but are not limited to continuing education, in-service training, or certification renewal. Persons qualified to be employed as surgical technologists shall complete fifteen (15) hours of continuing education or contact hours annually. Current certification by the National Board of Surgical Technology and Surgical Assisting shall satisfy this requirement.

(m) There must be a complete history and physical work-up in the chart of every patient prior to surgery, except in emergencies. If the history has been dictated, but not yet recorded in the patient's chart, there must be a statement to that effect and an admission note in the chart by the practitioner who admitted the patient.

~~(n) Properly executed informed consent, advance directive, if available, and organ donation forms, if available, must be in the patient's chart before surgery, except in emergencies.~~

(n) Properly executed informed consent, advance directive, if available, and organ donation forms, if available, must be in the patient's chart before surgery, except in emergencies. The patient is not required to sign advance directive and organ donation forms.

(o) Adequate equipment and supplies must be available as determined by the governing body and the medical staff, and must meet the current acceptable standards of practice in the ASTC industry. In conjunction with their governing body and the medical staff, the facility shall develop policies and procedures specifying the types of emergency equipment that are appropriate for the facility's patient population, and shall make the items immediately available at the ASTC to handle inter- or post-operative emergencies.

(p) At least one registered nurse shall be in the recovery area during the patient's recovery period.

(q) The operating room register must be complete and up-to-date.

(r) An operative report describing techniques, findings, and tissues removed or altered must be written or dictated immediately following surgery and signed by the surgeon.

(s) The ASTC shall provide one or more surgical suites which shall be constructed, equipped, and maintained to assure the safety of patients and personnel.

(t) Surgical suites are required to meet the same standards as hospital operating rooms, including those using general anesthesia.

(u) The ASTC shall have separate areas for waiting rooms, recovery rooms, treatment and/or examining rooms.

(2) Anesthesiology Services. Anesthesia shall be administered by:

(a) A qualified anesthesiologist;

(b) A doctor of medicine or osteopathy (other than an anesthesiologist);

(c) A dentist, oral surgeon, or podiatrist who is qualified to administer anesthesia under State law;

(Rule 1200-08-10-.06, continued)

(d) A certified registered nurse anesthetist (CRNA); or

(e) A graduate registered nurse anesthetist under the supervision of an anesthesiologist who is immediately available if needed.

(f) After the completion of anesthesia, patients shall be constantly attended by competent personnel until responsive and able to summon aid. Each center shall maintain a log of the inspections made prior to each day's use of the anesthesia equipment. A record of all service and maintenance performed on all anesthesia machines, vaporizers and ventilators shall also be on file.

(g) When inhaled general anesthesia known to trigger malignant hyperthermia and/or succinylcholine are maintained in the facility, there shall be thirty-six (36) ampules of Dantrolene for injection onsite. This requirement applies to anesthesia agents, current or future, that are shown to cause malignant hyperthermia. If Dantrolene is administered, appropriate monitoring must be provided post-operatively.

(h) Written policies and procedures relative to the administration of anesthesia shall be developed and approved by the Medical Staff and governing body.

(i) Any patient receiving conscious sedation shall receive:

1. continuous EKG monitoring;

2. continuous oxygen saturations;

3. serial BP monitoring at intervals no less than every 5 minutes; and

4. supplemental oxygen therapy and immediately available:

(i) ambubag;

(ii) suction;

(iii) endotracheal tube; and

(iv) crash cart.

(3) Medical Staff.

(a) The ASTC shall have a medical staff organized under written by-laws that are approved by the governing body. The medical staff of the ASTC shall define a mechanism to:

1. Assure that an optimal level of professional performance is maintained;

2. Appoint independent practitioners through a defined credentialing process;

3. Apply credentialing criteria uniformly;

4. Utilize the current license, relevant training and experience, current competence and the ability to perform requested privileges in the credentialing process; and

5. Provide for participation in required committees of the facility to ensure that quality medical care is provided to the patients.

(Rule 1200-08-10-.06, continued)

(b) Each licensed independent practitioner shall provide care under the auspices of the facility in accordance with approved privileges.

(c) Clinical privileges shall be granted based on the practitioners' qualifications and the services provided by the facility, and shall be reviewed and/or revised at least every two (2) years.

(4) Nursing Service. A licensed registered nurse (R.N.) shall be on duty at all times. Additional appropriately trained staff shall be provided as needed to ensure that the medical needs of the patients are fully met.

(a) The ASTC shall be organized under written policies and procedures relating to patient care, establishment of standards for nursing care and mechanisms for evaluating such care and nursing services.

(b) A qualified registered nurse designated by the administrator shall be responsible for coordinating and supervising all nursing services.

(c) There shall be a sufficient staffing pattern of registered nurses to provide quality nursing care to each surgical patient from admission through discharge. Additional staff shall be on duty and available to assist the professional staff to adequately handle routine and emergency patient needs.

(d) The ASTC shall establish written procedures for emergency services which will ensure that professional staff members who have been trained in emergency resuscitation procedures shall be on duty at all times when there is a patient in the ASTC and until the patient has been discharged.

(e) Nursing care policies and procedures shall be consistent with professionally recognized standards of nursing practice and shall be in accordance with the Nurse Practice Act of the State of Tennessee and the Association of Operating Room Nurses Standards of Practice.

(f) Staff development and training shall be provided to the nursing staff and other ancillary staff in order to maintain and improve knowledge and skills. The educational/training program shall be planned, documented and conducted on a continuing basis. There shall be at least appropriate training on equipment, safety concerns, infection control and emergency care on an annual basis.

(5) Pharmaceutical Services. The ASTC must provide drugs and biologicals in a safe and effective manner in accordance with accepted standards of practice. Such drugs and biologicals must be stored in a separate room or cabinet which shall be kept locked at all times.

(6) Ancillary Services. All ancillary or supportive health or medical services, including but not limited to, radiological, pharmaceutical, or medical laboratory services shall be provided in accordance with all applicable state and federal laws and regulations.

(7) Radiological Services. The ASTC shall provide within the facility, or through arrangement, diagnostic radiological services commensurate with the needs of the ambulatory surgical treatment center.

(a) If radiological services are provided by facility staff, the services shall be maintained free of hazards for patients and personnel.

(Rule 1200-08-10-.06, continued)

(b) New installations of radiological equipment, and subsequent inspections for the identification of radiation hazards shall be made as specified in state and federal requirements.

(c) Personnel monitoring shall be maintained for each individual working in the area of radiation. Readings shall be on at least a monthly basis and reports kept on file and available for review.

1. Personnel - The ASTC shall have a radiologist either full-time or part-time on a consulting basis, both to supervise the service and to discharge professional radiological services.

2. The use of all radiological apparatus shall be limited to personnel designated as qualified by the radiologist; and use of fluoroscopes shall be limited to physicians.

(d) If provided under arrangement with an outside provider, the radiological services must be directed by a qualified radiologist and meet state and federal requirements.

(8) Laboratory Services.

(a) The ASTC shall provide on the premises or by written agreement with a laboratory licensed under T.C.A. 68-29-105, a clinical laboratory to provide those services commensurate with the needs and services of the ASTC.

(b) Any patient terminating pregnancy in an ASTC shall have an Rh type, documented prior to the procedure, performed on her blood. In addition, she shall be given the opportunity to receive Rh immune globulin after an appropriate crossmatch procedure is performed within a licensed laboratory.

(9) Food and Dietetic Services. If a patient will be in the facility for more than four (4) hours post-op, an appropriate diet shall be provided.

(10) Environmental Services.

(a) The facility shall provide a safe, accessible, effective and efficient environment of care consistent with its mission, service, law and regulation.

(b) The facility shall develop policies and procedures that address:

1. Safety;

2. Security;

3. Control of hazardous materials and waste;

4. Emergency preparedness;

5. Life safety;

6. Medical equipment; and,

7. Utility systems.

(Rule 1200-08-10-.06, continued)

(c) Staff shall have been oriented to and educated about the environment of care and possess knowledge and skills to perform responsibilities under the environment of care policies and procedures.

(d) Utility systems, medical equipment, life safety elements, and safety elements of the environment of care shall be maintained, tested and inspected.

(e) Safety issues shall be addressed and resolved.

(f) Appropriate staff shall participate in implementing safety recommendations and monitoring their effectiveness.

(g) The building and grounds shall be suitable to services provided and patients served.

(11) Medical Records.

(a) The ASTC shall comply with the Medical Records Act of 1974, T.C.A. § 68-11-301, et seq.

(b) A medical record shall be maintained for each person receiving medical care provided by the ASTC and shall include:

1. Patient identification;

2. Name of nearest relative or other responsible agent;

3. Identification of primary source of medical care;

4. Dates and times of visits;

5. Signed informed consent;

6. Pertinent medical history;

7. Diagnosis;

8. Physician examination report;

9. Anesthesia records of pertinent preoperative and postoperative reports including preanesthesia evaluation, type of anesthesia, technique and dosage used;

10. Operative report;

11. Discharge summary, including instructions for self care and instructions for obtaining postoperative emergency care;

12. Reports of all laboratory and diagnostic procedures along with tests performed and the results authenticated by the appropriate personnel; and,

13. X-ray reports.

(c) Medical records shall be current and confidential. Medical records and copies thereof shall be made available when requested by an authorized representative of the board or the department.

(Rule 1200-08-10-.06, continued)

(12) Invasive Procedures

(a) Only a medical doctor, licensed pursuant to *T.C.A. § 63-6-101 et seq.*, or an osteopathic physician, licensed pursuant to *T.C.A. § 63-9-101 et seq.*, who meet the following qualifications will be permitted to perform invasive procedures of the spine, spinal cord, sympathetic nerves of the spine or block of major peripheral nerves of the spine:

1. Board certified through the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA) or the American Board of Physician Specialties (ABPS)/American Association of Physician Specialists (AAPS) in one of the following medical specialties:

(i) Anesthesiology;

(ii) Neurological surgery, or Neuromusculoskeletal medicine;

(iii) Orthopedic surgery;

(iv) Physical medicine and rehabilitation;

(v) Radiology; or

(vi) Any other board certified physician who had completed an ABMS subspecialty board in pain medicine or completed an ACGME accredited pain fellowship;

2. A recent graduate in a medical specialty listed in part 1 not yet eligible to apply for ABMS, AOA, or ABPS/AAPS board certification; provided, there is a practice relationship with a medical doctor or an osteopathic physician who meets the requirements of part 1.;

3. A licensee who is not board certified in one of the specialties listed in part 1, but is board certified in a different ABMS, AOA, or ABPS/AAPS specialty and has completed a post-graduate training program in interventional pain management approved by the board;

4. A licensee who serves as a clinical instructor in pain medicine at an accredited Tennessee medical training program; or

5. A licensee who has an active pain management practice in a clinic accredited in outpatient interdisciplinary pain rehabilitation by the Commission on Accreditation of Rehabilitation Facilities or any successor organizations.

(b) An advanced practice nurse or physician assistant shall only perform invasive procedures involving any portion of the spine, spinal cord, sympathetic nerves of the spine or block of major peripheral nerves of the spine under the direct supervision of a medical doctor or an osteopathic physician who meets the qualifications of Rule 1200-08-10-.06 (12)(a)1 or 3. Direct supervision is defined as being physically present in the center at the time the invasive procedure is performed.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 68-11-201, 68-11-202, 68-11-204, 68-11-206, 68, 68-11-209, 68-11-216, 68-57-101, 68-57-102, 68-57-104, and 68-57-105.* ***Administrative History:*** *Original rule filed July 22, 1977; effective August 22, 1977. Amendment filed September 10, 1991; effective October 25, 1991. Repeal and new rule filed June 30, 1992; effective August 14, 1992. Repeal and new rule filed*

(Rule 1200-08-10-.06, continued)
March 21, 2000; effective June 4, 2000. Amendment filed June 16, 2003; effective August 30, 2003. Amendment filed February 23, 2006; effective May 9, 2006. Amendment filed February 23, 2007; effective May 9, 2007. Amendment filed February 22, 2010; effective May 23, 2010. Amendment filed January 3, 2012; effective April 2, 2012. Amendment filed December 16, 2013; effective March 16, 2014. Amendments filed March 27, 2015; effective June 25, 2015.

1200-08-10-.07 RESERVED.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, 68-11-209, and 68-57-105.* ***Administrative History:*** *Original rule filed June 30, 1992; effective August 14, 1992. Repeal and new rule filed March 4, 2000; effective June 4, 2000. Amendment filed June 16, 2003; effective August 30, 2003. Amendment filed January 3, 2012; effective April 2, 2012.*

1200-08-10-.08 BUILDING STANDARDS.

(1) An ASTC shall construct, arrange, and maintain the condition of the physical plant and the overall ASTC environment in such a manner that the safety and well-being of the patients are assured.

(2) After the applicant has submitted an application and licensure fees, the applicant must submit the building construction plans to the department. All new facilities shall conform to the 2006 edition of the International Building Code, except for Chapter 11 pertaining to accessibility and except for Chapter 27 pertaining to electrical requirements; the 2006 edition of the International Mechanical Code; the 2006 edition of the International Plumbing Code; the 2006 edition of the International Fuel and Gas Code; the 2006 edition of the National Fire Protection Code (NFPA) NFPA 1 including Annex A which incorporates the 2006 edition of the Life Safety Code; the 2010 Guidelines for Design and Construction of Health Care Facilities; and the 2005 edition of the National Electrical Code. The requirements of the 2004 Americans with Disabilities Act (A.D.A.), and the 1999 edition of North Carolina Handicap Accessibility Codes with 2004 amendments apply to all new facilities and to all existing facilities that are enlarged or substantially altered or repaired after July 1, 2006. When referring to height, area or construction type, the International Building Code shall prevail. Where there are conflicts between requirements in local codes, the above listed codes and regulations and provisions of this chapter, the most stringent requirements shall apply.

(3) The codes in effect at the time of submittal of plans and specifications, as defined by these rules, shall be the codes to be used throughout the project.

(4) The licensed contractor shall perform all new construction and renovations to ASTCs, other than minor alterations not affecting fire and life safety or functional issues, in accordance with the specific requirements of these regulations governing new construction in ASTCs, including the submission of phased construction plans and the final drawings and the specifications to each.

(5) No new ASTC shall be constructed, nor shall major alterations be made to an existing ASTC without prior written approval of the department, and unless in accordance with plans and specifications approved in advance by the department. Before any new ASTC is licensed or before any alteration or expansion of a licensed ASTC can be approved, the applicant must furnish two (2) complete sets of plans and specifications to the department, together with fees and other information as required. Plans and specifications for new construction and major renovations, other than minor alterations not affecting fire and life safety or functional issues, shall be prepared by or under the direction of a licensed architect and/or a licensed

(Rule 1200-08-35-.05, continued)

(c) Any duly licensed out of state health care professional who is authorized by his or her state board to order outpatient diagnostic testing in hospitals for individuals with whom that practitioner has an existing face-to-face patient relationship as outlined in rule 0880-02-.14(7)(a)1., 2., and 3.

(3) The facility shall ensure that no person on the grounds of race, color, national origin, or handicap, will be excluded from participation in, be denied benefits of, or otherwise subjected to discrimination in the provision of any care or service of the facility. The facility shall protect the civil rights of residents under the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973.

(4) For purposes of this chapter, and when applicable, the requirements for signature or countersignature by a physician responsible for signing, countersigning or authenticating an entry may be satisfied by the electronic entry by such person of a unique code assigned exclusively to him or her, or by entry of other unique electronic or mechanical symbols, provided that such person has adopted same as his or her signature in accordance with established Outpatient Diagnostic Center protocol or rules.

(5) The Outpatient Diagnostic Center shall have available a plan for emergency transportation to a licensed local hospital.

(6) As needed, the patient and family members or interested persons must be taught and/or counseled to prepare them for post procedural care.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-209, and 68-11-216.* ***Administrative History:*** *Original rule filed October 26, 2005; effective January 9, 2006.*

1200-08-35-.06 BASIC SERVICES.

(1) Radiological services. If laboratory tests are performed in the nuclear medicine services, they shall meet applicable requirements for laboratory services as specified in T.C.A. 68-29-101 et seq.

(a) Radiological services provided shall be maintained free of hazards for patients and personnel.

(b) Personnel monitoring shall be maintained for each individual working in the area of radiation. Readings shall be on at least a monthly basis and reports kept on file and available for review.

(c) Patients, employees and the general public shall be provided protection from radiation in accordance with "State Regulations for Protection Against Radiation". All radiation producing equipment shall be registered and all radioactive material shall be licensed by the Division of Radiological Health of the Tennessee Department of Environment and Conservation.

(d) Periodic inspections of equipment must be made and hazards identified must be promptly corrected.

(e) Radiology personnel shall be qualified by education, training and experience for the type of service rendered.

(f) X-rays shall be retained for four (4) years and may be retired thereafter provided that a signed interpretation by a radiologist is maintained in the patient's record under T.C.A. §68-11-305.

(Rule 1200-08-35-.06, continued)

(g) Patient safety shall be ensured in all areas of the facility.

(h) Radioactive materials must be prepared, labeled, used, transported, stored, and disposed of in accordance with acceptable standards of practice.

(i) In-house preparation of radiopharmaceuticals shall be accomplished by, or under the direct supervision of, an appropriately trained registered pharmacist or a doctor of medicine or osteopathy.

(j) The Outpatient Diagnostic Center shall maintain records of the receipt and disposition of radiopharmaceuticals.

(2) Invasive Procedures.

(a) If the facility provides invasive diagnostic procedures eg. cardiac catheterization, percutaneous transluminal coronary angioplasty, vascular embolization or stereotactic procedures using anesthesia, the services must be well organized and provided in accordance with acceptable standards of practice.

~~(b) A qualified registered nurse shall be present during invasive diagnostic procedures.~~

(b) A qualified registered nurse shall be present during invasive diagnostic procedures, as listed in subparagraph (2)(a), where anything greater than local anesthesia is used during a procedure.

(c) Properly executed informed consent forms shall be in the patient's chart before procedure is performed, except in emergencies.

(d) Adequate equipment and supplies shall be available to the invasive diagnostic room and to the post procedure care area. The following equipment and supplies shall be provided for cardiac catheterization or angioplasty:

1. Call-in system
2. Cardiac monitor
3. Pulse Oximeter
4. Resuscitator
5. Defibrillator
6. Aspirator
7. Tracheotomy set

(e) A crash cart must be available with appropriate medications.

~~(f) A qualified registered nurse shall be in the post procedure area during the patient's recovery period.~~

(f) A qualified registered nurse shall be in the post procedure area during the patient's recovery period during invasive diagnostic procedures, as listed in subparagraph (2)(a), where anything greater than local anesthesia is used during a procedure.

(Rule 1200-08-35-.06, continued)

(g) A report describing techniques, findings, and tissues removed or altered must be written or dictated immediately following the procedure and signed by the physician.

(h) The Outpatient Diagnostic Center shall provide one or more procedure rooms which shall be constructed, equipped, and maintained to assure the safety of patients and personnel.

(3) Anesthesia. General anesthesia shall not be administered in Outpatient Diagnostic Centers.

(a) Written policies and procedures relative to the administration of anesthesia shall be developed and approved by the governing body, or responsible individual.

(b) After the completion of anesthesia, patients shall be constantly attended by competent personnel until responsive and able to summon aid. Each center shall maintain a log of the inspections made prior to each day's use of the anesthesia equipment. A record of all service and maintenance performed on all anesthesia machines shall also be on file.

(c) Any patient receiving conscious sedation shall receive:

1. continuous EKG monitoring;

2. continuous oxygen saturations;

3. serial BP monitoring at intervals no less than every 5 minutes; and

4. supplemental oxygen therapy and immediately available:

(i) ambubag;

(ii) suction;

(iii) endotracheal tube; and

(iv) crash cart.

(4) Pharmaceutical Services. The Outpatient Diagnostic Center must provide drugs and biologicals in a safe and effective manner in accordance with accepted federal and state standards of practice. Such drugs and biologicals must be stored in a separate room or cabinet which shall be kept locked at all times.

(5) Environmental Services.

(a) The facility shall provide a safe, accessible, effective and efficient environment of care consistent with its mission, service, law and regulation.

(b) The facility shall develop policies and procedures that address:

1. Safety;

2. Security;

3. Control of hazardous materials and waste;

4. Emergency preparedness;

5. Life safety;

(Rule 1200-08-35-.06, continued)

6. Medical equipment; and,

7. Utility systems.

(c) Staff shall have been oriented to and educated about the environment of care and possess knowledge and skills to perform responsibilities under the environment of care policies and procedures.

(d) Utility systems, medical equipment, life safety elements, and safety elements of the environment of care shall be maintained, tested and inspected.

(e) Safety issues shall be addressed and resolved.

(f) Appropriate staff shall participate in implementing safety recommendations and monitoring their effectiveness.

(g) The building and grounds shall be suitable to services provided and patients served.

(6) Medical Records.

(a) The Outpatient Diagnostic Center shall comply with the Medical Records Act of 1974, T.C.A. § 68-11-301, et seq.

(b) A medical record shall be maintained for each person receiving services provided by the Outpatient Diagnostic Center and shall include:

1. Patient identification;

2. Name of nearest relative or other responsible agent;

3. Identification of primary source of medical care;

4. Dates and times of visits;

5. Signed informed consent;

6. Operative report;

7. Reports of all laboratory and diagnostic procedures along with tests performed and the results authenticated by the appropriate personnel; and,

8. Radiology reports.

(c) Medical records shall be current and confidential. Medical records and copies thereof shall be made available when requested by an authorized representative of the board or the department.

(7) Infection Control.

(a) The Outpatient Diagnostic Center must provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There must be an active performance improvement program for the prevention, control, and investigation of infections and communicable diseases.

(Rule 1200-08-35-.06, continued)

(b) The facility shall develop policies and procedures for testing a patient's blood for the presence of the hepatitis B virus and the HIV (AIDS) virus in the event that an employee of the facility, a student studying at the facility, or other health care provider rendering services at the facility is exposed to a patient's blood or other body fluid. The testing shall be performed at no charge to the patient, and the test results shall be confidential.

(c) The facility and its employees shall adopt and utilize standard precautions (per CDC) for preventing transmission of infections, HIV, and communicable diseases.

(d) All Outpatient Diagnostic Center's shall adopt appropriate policies regarding the testing of patients and staff for human immunodeficiency virus (HIV) and any other identified causative agent of acquired immune deficiency syndrome.

(e) The physical environment of the facility shall be maintained in a safe, clean and sanitary manner.

(f) Any condition on the facility site conducive to the harboring or breeding of insects, rodents or other vermin shall be prohibited. Chemical substances of a poisonous nature used to control or eliminate vermin shall be properly identified. Such substances shall not be stored with or near food or medications.

(8) Performance Improvement. The Outpatient Diagnostic Center shall have a planned, systematic, organization-wide approach to process design and redesign, performance measurement, assessment and improvement which is approved by the designated governing body or responsible individual. This plan shall address and/or include, but is not limited to:

(a) Infection control, including post-operative surveillance;

(b) Complications of procedures;

(c) Documentation of periodic review of the data collected and follow-up actions;

(d) A system which identifies appropriate plans of action to correct identified quality deficiencies;

(e) Documentation that the above policies are being followed and that appropriate action is taken whenever indicated.

(9) Ancillary Services. All ancillary or supportive health or medical services, including but not limited to, dietary, environmental, nursing, or medical laboratory services shall be provided in accordance with all applicable state and federal laws and regulations.

(10) Laboratory Services.

(a) The Outpatient Diagnostic Center shall provide on the premises or by written agreement with a laboratory licensed under T.C.A. 68-29-105, a clinical laboratory to provide those services commensurate with the needs and services of the Outpatient Diagnostic Center.

(b) Any patient terminating pregnancy in an Outpatient Diagnostic Center shall have an Rh type, documented prior to the procedure, performed on her blood. In addition, she shall be given the opportunity to receive Rh immune globulin after an appropriate crossmatch procedure is performed within a licensed laboratory.

(Rule 1200-08-35-.06, continued)

(11) Food and Dietetic Services. If a patient will be in the facility for more than four (4) hours post-op, an appropriate diet shall be provided.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-209, and 68-11-216.* ***Administrative History:*** *Original rule filed October 26, 2005; effective January 9, 2006.*

1200-08-35-.07 RESERVED.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-209, and 68-11-216.* ***Administrative History:*** *Original rule filed October 26, 2005; effective January 9, 2006.*

1200-08-35-.08 BUILDING STANDARDS.

(1) An ODC shall construct, arrange, and maintain the condition of the physical plant and the overall ODC environment in such a manner that the safety and well-being of the patients are assured.

(2) After the applicant has submitted an application and licensure fees, the applicant must submit the building construction plans to the department. All new facilities shall conform to the 2006 edition of the International Building Code, except for Chapter 11 pertaining to accessibility and except for Chapter 27 pertaining to electrical requirements; the 2006 edition of the International Mechanical Code; the 2006 edition of the International Plumbing Code; the 2006 edition of the International Fuel and Gas Code; the 2006 edition of the National Fire Protection Code (NFPA) NFPA 1 including Annex A which incorporates the 2006 edition of the Life Safety Code; the 2010 Guidelines for Design and Construction of Health Care Facilities; and the 2005 edition of the National Electrical Code. The requirements of the 2004 Americans with Disabilities Act (A.D.A.), and the 1999 edition of North Carolina Handicap Accessibility Codes with 2004 amendments apply to all new facilities and to all existing facilities that are enlarged or substantially altered or repaired after July 1, 2006. When referring to height, area or construction type, the International Building Code shall prevail. Where there are conflicts between requirements in local codes, the above listed codes and regulations and provisions of this chapter, the most stringent requirements shall apply.

(3) The codes in effect at the time of submittal of plans and specifications, as defined by these rules, shall be the codes to be used throughout the project.

(4) The licensed contractor shall perform all new construction and renovations to ODCs, other than minor alterations not affecting fire and life safety or functional issues, in accordance with the specific requirements of these regulations governing new construction in ODCs, including the submission of phased construction plans and the final drawings and the specifications to each.

(5) No new ODC shall be constructed, nor shall major alterations be made to an existing ODC without prior written approval of the department, and unless in accordance with plans and specifications approved in advance by the department. Before any new ODC is licensed or before any alteration or expansion of a licensed ODC can be approved, the applicant must furnish two (2) complete sets of plans and specifications to the department, together with fees and other information as required. Plans and specifications for new construction and major renovations, other than minor alterations not affecting fire and life safety or functional issues, shall be prepared by or under the direction of a licensed architect and/or a licensed engineer and in accordance with the rules of the Board of Architectural and Engineering Examiners.

* If a roll-call vote was necessary, the vote by the Agency on these rulemaking hearing rules was as follows:

Board Member	Aye	No	Abstain	Absent	Signature (if required)
Carissa S. Lynch, Pharm.D.	X				
Michael R. Miller				X	
Diana L. Miller	X				
Robert Gordon				X	
John A. Marshall	X				
Jennifer Gordon-Maloney, DDS	X				
Kenneth R. Robertson, M.D.	X				
Sherry Robbins, M.D.	X				
Annette Marlar				X	
Robert C. Breeden	X				
Roger L. Mynatt	X				
Janet Williford	X				
David Rhodes	X				
Joshua A. Crisp	X				
Betty S. Hodge	X				
Bobby Wood	X				
Jim Shulman	X				

I certify that this is an accurate and complete copy of rulemaking hearing rules, lawfully promulgated and adopted by the Board for Licensing Health Care Facilities (board/commission/ other authority) on 01/21/2015 (mm/dd/yyyy), and is in compliance with the provisions of T.C.A. § 4-5-222.

I further certify the following:

Notice of Rulemaking Hearing filed with the Department of State on: *09/29/14 (mm/dd/yy)*

Rulemaking Hearing(s) Conducted on: (add more dates). *01/21/15 (mm/dd/yy)*

Date: 10-5-2015

Signature:

Name of Officer: Devin M. Wells

Title of Officer: Deputy General Counsel, Department of Health

Subscribed and sworn to before me on: 10-5-15

Notary Public Signature:

My commission expires on: MY COMMISSION EXPIRES APRIL 19, 2017

SUZANNE MECHKOWSKI NOTARY PUBLIC STATE OF TENNESSEE SUMNER COUNTY

Board for Licensing Health Care Facilities Rules
Rules 1200-08-10-.06 and 1200-08-35-.06
Standards for Ambulatory Surgical Treatment Centers and
for Outpatient Diagnostic Centers
Basic Services

All rulemaking hearing rules provided for herein have been examined by the Attorney General and Reporter of the State of Tennessee and are approved as to legality pursuant to the provisions of the Administrative Procedures Act, Tennessee Code Annotated, Title 4, Chapter 5.

Herbert H. Slatery III
Herbert H. Slatery III
Attorney General and Reporter

10/14/2015
Date

Department of State Use Only

Filed with the Department of State on: 10-20-15

Effective on: 1-18-16

Tre Hargett
Secretary of State

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PUBLICATIONS

G.O.C. STAFF RULE ABSTRACT

BOARD:	Board for Licensing Health Care Facilities
SUBJECT:	Standards for Nursing Homes
STATUTORY AUTHORITY:	Tennessee Code Annotated, Sections 68-11-209 and 68-11-256(a)
EFFECTIVE DATES:	January 18, 2016 through June 30, 2016
FISCAL IMPACT:	None
STAFF RULE ABSTRACT:	This rulemaking hearing rule makes the rules consistent with the present law requirement that persons who are employed by nursing homes for a position that requires providing direct care to a resident or patient must undergo a criminal background check prior to employment.

Public Hearing Comments

One copy of a document containing responses to comments made at the public hearing must accompany the filing pursuant to T.C.A. § 4-5-222. Agencies shall include only their responses to public hearing comments, which can be summarized. No letters of inquiry from parties questioning the rule will be accepted. When no comments are received at the public hearing, the agency need only draft a memorandum stating such and include it with the Rulemaking Hearing Rule filing. Minutes of the meeting will not be accepted. Transcripts are not acceptable.

There were no public comments, either written or oral.

Regulatory Flexibility Addendum
Pursuant to T.C.A. §§ 4-5-401 through 4-5-404, prior to initiating the rule making process as described in T.C.A. § 4-5-202(a)(3) and T.C.A. § 4-5-202(a), all agencies shall conduct a review of whether a proposed rule or rule affects small businesses.

REGULATORY FLEXIBILITY ANALYSIS

(1) The extent to which the rule or rule may overlap, duplicate, or conflict with other federal, state, and local governmental rules.

This rule amendment does not overlap, duplicate, or conflict with other federal, state, and local government rules.

(2) Clarity, conciseness, and lack of ambiguity in the rule or rules.

This rule amendment establishes clarity, conciseness, and lack of ambiguity because this amendment will bring the rule in line with T.C.A. § 68-11-256(a).

(3) The establishment of flexible compliance and/or reporting requirements for small businesses.

This rule amendment does not create any new compliance or reporting requirements.

(4) The establishment of friendly schedules or deadlines for compliance and/or reporting requirements for small businesses.

This rule amendment does not create any new compliance or reporting requirements.

(5) The consolidation or simplification of compliance or reporting requirements for small businesses.

This rule amendment does not consolidate or simplify compliance or reporting requirements for small businesses. The rule is being changed in order to comply with T.C.A. § 68-11-256(a).

(6) The establishment of performance standards for small businesses as opposed to design or operational standards required in the proposed rule.

This rule amendment does not establish performance standards for small businesses as opposed to design or operational standards required for the proposed rule.

(7) The unnecessary creation of entry barriers or other effects that stifle entrepreneurial activity, curb innovation, or increase costs.

This rule amendment does not create unnecessary barriers or other effects that stifle entrepreneurial activity, curb innovation, or increase costs.

STATEMENT OF ECONOMIC IMPACT TO SMALL BUSINESSES

Name of Board, Committee or Council: Board for Licensing Health Care Facilities

Rulemaking hearing date: January 21, 2015

1. **Type or types of small business and an identification and estimate of the number of small businesses subject to the proposed rule that would bear the cost of, and/or directly benefit from the proposed rule:**

   This rule amendment will affect all persons seeking employment at nursing homes who will be directly involved with patient care as well as businesses operating as nursing homes. The 328 licensed nursing homes in Tennessee will benefit from the reduction in potential legal liability due to hiring someone with direct resident/patient access whose criminal background check demonstrates that the person should not have been hired and may be a danger to the residents/patients. Further, the vulnerable residents/patients are not exposed to potential harm during the seven day window that the current rule allows.

2. **Projected reporting, recordkeeping and other administrative costs required for compliance with the proposed rule, including the type of professional skills necessary for preparation of the report or record:**

   This rule amendment creates consistency between current rule and statutory language and, therefore, will have no impact on current reporting, recordkeeping and administrative costs. Nursing homes are currently complying with the statute.

3. **Statement of the probable effect on impacted small businesses and consumers:**

   Businesses should be positively impacted by this rule amendment due to the aforementioned decreased legal liability. The consumers (patients/residents) will be protected from potential harm.

4. **Description of any less burdensome, less intrusive or less costly alternative methods of achieving the purpose and/or objectives of the proposed rule that may exist, and to what extent, such alternative means might be less burdensome to small business:**

   There are no less burdensome, less intrusive or less costly alternative methods of achieving the purpose and/or objectives of the proposed rule.

5. **Comparison of the proposed rule with any federal or state counterparts:**

   Federal: None.

   State: None.

6. **Analysis of the effect of the possible exemption of small businesses from all or any part of the requirements contained in the proposed rule.**

   This rule change is mandated by statutory authority, and as a result, does not provide for exemptions for small businesses.

Impact on Local Governments

Pursuant to T.C.A. §§ 4-5-220 and 4-5-228 "any rule proposed to be promulgated shall state in a simple declarative sentence, without additional comments on the merits of the policy of the rules or regulation, whether the rule or regulation may have a projected impact on local governments." (See Public Chapter Number 1070 (http://state.tn.us/sos/acts/106/pub/pc1070.pdf) of the 2010 Session of the General Assembly)

Some local governments own nursing homes. So, this rule would have an impact on the hiring process of those nursing homes owned by local governments. However, most, if not all, nursing homes are currently complying with the current statutory language of T.C.A. § 68-11-256(a).

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For Department of State Use Only

Sequence Number: 10-16-15
Rule ID(s): 6062
File Date: 10-20-15
Effective Date: 1-18-16

Rulemaking Hearing Rule(s) Filing Form

Rulemaking Hearing Rules are rules filed after and as a result of a rulemaking hearing (Tenn. Code Ann. § 4-5-205).

Pursuant to Tenn. Code Ann. § 4-5-229, any new fee or fee increase promulgated by state agency rule shall take effect on July 1, following the expiration of the ninety (90) day period as provided in § 4-5-207. This section shall not apply to rules that implement new fees or fee increases that are promulgated as emergency rules pursuant to § 4-5-208(a) and to subsequent rules that make permanent such emergency rules, as amended during the rulemaking process. In addition, this section shall not apply to state agencies that did not, during the preceding two (2) fiscal years, collect fees in an amount sufficient to pay the cost of operating the board, commission or entity in accordance with § 4-29-121(b).

Agency/Board/Commission:	Department of Health
Division:	Board for Licensing Health Care Facilities
Contact Person:	Devin M. Wells Deputy General Counsel
Address:	665 Mainstream Drive, Nashville, Tennessee
Zip:	37243
Phone:	(615) 741-1611
Email:	Devin.M.Wells@tn.gov

Revision Type (check all that apply):

X Amendment
___ New
___ Repeal

Rule(s) Revised (**ALL** chapters and rules contained in filing must be listed here. If needed, copy and paste additional tables to accommodate multiple chapters. Please enter only **ONE** Rule Number/Rule Title per row)

Chapter Number	**Chapter Title**
1200-08-06	Standards for Nursing Homes
Rule Number	**Rule Title**
1200-08-06-.04	Administration

(Rule 1200-08-06-.03, continued)

(14) Reconsideration and Stays. The Board authorizes the member who chaired the Board for a contested case to be the agency member to make the decisions authorized pursuant to rule 1360-04-01-.18 regarding petitions for reconsiderations and stays in that case.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 4-5-219, 4-5-312, 4-5-316, 4-5-317, 68-11-202, 68-11-204, and 68-11-206 through 68-11-209.* ***Administrative History:*** *Original rule filed March 27, 1975; effective April 25, 1975. Repeal and new rule filed July 14, 1983; effective August 15, 1983. Amendment filed March 13, 1986; effective April 12, 1986. Amendment filed December 30, 1986; effective February 13, 1987. Repeal and new rule filed January 31, 2000; effective April 15, 2000. Amendment filed May 24, 2004; August 7, 2004. Amendment filed March 1, 2007; effective May 15, 2007.*

1200-08-06-.04 ADMINISTRATION.

(1) The nursing home shall have a full-time (working at least 32 hours per week) administrator licensed in Tennessee, who shall not function as the director of nursing. Any change of administrators shall be reported in writing to the department within fifteen (15) days. The administrator shall designate in writing an individual to act in his/her absence in order to provide the nursing home with administrative direction at all times. The administrator shall assure the provision of appropriate fiscal resources and personnel required to meet the needs of the residents.

(2) The hospital administrator may serve as the administrator of a hospital-based nursing home provided that he/she is a Tennessee licensed nursing home administrator, the facilities are located on the same campus, and the surveys do not reflect substandard care.

(3) Any agreement to manage a nursing home must be reported in writing to the department within fifteen (15) days of its implementation.

(4) Upon the unexpected loss of the facility administrator, the facility shall proceed according to the following provisions:

(a) The term "unexpected loss" means the absence of a nursing home administrator due to serious illness or incapacity, unplanned hospitalization, death, resignation with less than thirty (30) days notice or unplanned termination.

(b) The facility must notify the department within twenty-four (24) hours after notice of the unexpected loss of the administrator. Notification to the department shall identify an individual to be responsible for administration of the facility for the immediate future not to exceed thirty (30) days. This responsible individual need not be licensed as an administrator and may be the facility's director of nursing.

(c) Within seven (7) days of notice of the unexpected loss, the facility must request a waiver of the appropriate regulations from the board.

(d) On or before the expiration of thirty (30) days after notice of the unexpected loss, the facility shall appoint a temporary administrator to serve until either a permanent administrator is employed or the request for a waiver is considered by the board, whichever occurs first. The temporary administrator shall be any of the following:

1. A full-time administrator licensed in Tennessee or any other state;

2. One (1) or more part-time administrators licensed in Tennessee. Part-time shall not be less than twenty (20) hours per week; or,

3. A full-time candidate for licensure as a Tennessee administrator who has completed the required training and the application process. Such candidate

(Rule 1200-08-06-.04, continued)

shall be scheduled for the next licensure exam and is eligible for the continued administrator role only with the successful completion of that exam.

(e) The procedures set forth above shall be followed until the next regularly scheduled meeting of the board in which the board considers the facility's application for a waiver. After reviewing the circumstances, the board may grant, refuse or condition a waiver as necessary to protect the health, safety and welfare of the residents in the facility.

(f) Any facility which follows these procedures shall not be subject to a civil penalty for absence of an administrator at any time preceding the board's consideration of the facility's request for a waiver.

(5) The facility shall make reasonable efforts to safeguard personal property and promptly investigate complaints of such loss. A record shall be prepared of all clothing, personal possessions and money brought by the resident to the nursing home at the time of admission. The record shall be filled out in duplicate. One copy of the record shall be given to the resident or the resident's representative and the original shall be maintained in the nursing home record. This record shall be updated as additional personal property is brought to the facility.

(6) The facility shall maintain a surety bond on all resident funds held in trust. Such surety bonds shall be sufficient to cover the amount of such funds. The surety bond shall be an agreement between the company issuing the bond and the nursing home and shall remain in the possession of the nursing home.

(7) If the facility holds resident funds, such funds shall be kept in an account separate from the facility's funds. Resident funds shall not be used by the facility. The facility shall maintain and allow each resident access to a written record of all financial arrangements and transactions involving the individual resident's funds. The facility shall provide each resident or his/her representative with a written itemized statement at least quarterly of all financial transactions involving the resident's funds.

(8) Within thirty (30) days of a resident's death, the facility shall provide an accounting of the resident's funds held by the facility and an inventory of the resident's personal property held by the facility to the resident's executor, administrator or other person authorized by law to receive the decedent's property. The facility shall obtain a signed receipt from any person to whom the decedent's property is transferred.

(9) Upon the sale of the facility, the seller shall provide written verification that all the resident's funds and property have been transferred and shall obtain a signed receipt from the new owner. Upon receipt, the buyer shall provide, to the residents, an accounting of funds and property held on their behalf.

(10) When licensure is applicable for a particular job, verification of the current license must be included as a part of the personnel file. Each personnel file shall contain accurate information as to the education, training, experience and personnel background of the employee. Documentation that references were verified shall be on file. Documentation that all appropriate abuse registries have been checked shall be on file. Adequate medical screenings to exclude communicable disease shall be required of each employee.

~~(11) All nursing homes shall initiate a criminal background check on any person who is employed by the facility in a position which involves providing direct care to a resident or patient, prior to or within seven (7) days of employment.~~

(Rule 1200-08-06-.04, continued)

(11) Prior to employment, all nursing homes shall complete a criminal background check on any person who will be in a position which involves providing direct care to a resident or patient.

(a) Any person who applies for employment in a position which involves providing direct patient care to a resident in such a facility shall consent to:

1. Provide past work and personal references to be checked by the nursing home; and/or

2. Agree to release and use of any and all information and investigative records necessary for the purpose of verifying whether the individual has been convicted of a criminal offense in the state of Tennessee, to either the nursing home or its agent, to any agency that contracts with the state of Tennessee, to any law enforcement agency, or to any other legally authorized entity; and/or

3. Supply a fingerprint sample and submit to a state criminal history records check to be conducted by the Tennessee Bureau of Investigations, or a state and federal criminal history records check to be conducted by the Tennessee Bureau of Investigation and the Federal Bureau of Investigation; and/or

4. Release any information required for a criminal background investigation by a professional background screening organization or criminal background check service or registry.

(b) A nursing home shall not disclose criminal background check information obtained to a person who is not involved in evaluating a person's employment, except as required or permitted by state or federal law.

(c) Any costs incurred by the Tennessee Bureau of Investigation, professional background screening organization, law enforcement agency, or other legally authorized entity, in conducting such investigations of such applicants may be paid by the nursing home, or any agency that contracts with the state of Tennessee requesting such investigation and information, or the individual who seeks employment or is employed. Payment of such costs to the Tennessee Bureau of Investigation are to be made in accordance with T.C.A. §§38-6-103 and 38-6-109. The costs of conducting criminal background checks shall be an allowable cost under the state Medicaid program, if paid for by the nursing home.

(d) Criminal background checks are also required by any organization, company, or agency that provides or arranges for the supply of direct care staff to any nursing home licensed in the state of Tennessee. Such company, organization, or agency shall be responsible for initiating a criminal background check on any person hired by that entity for the purpose of working in a nursing home, and shall be required to report the results of the criminal background check to any facility in which the organization arranges the employee to work, upon request by a facility.

(e) A nursing home that declines to employ or terminates a person based upon criminal background information provided to the facility shall be immune from suit by or on behalf of that person for the termination of or the refusal to employ that person.

(12) Whenever the rules of this chapter require that a licensee develop a written policy, plan, procedure, technique, or system concerning a subject, the licensee shall develop the required policy, maintain it and adhere to its provisions. A nursing home which violates a required policy also violates the rule establishing the requirement.

(Rule 1200-08-06-.04, continued)

(13) Policies and procedures shall be consistent with professionally recognized standards of practice.

(14) No nursing home shall retaliate against or, in any manner, discriminate against any person because of a complaint made in good faith and without malice to the board, the department, the Department of Human Services Adult Protective Services, the long term care ombudsman, the Comptroller of the State Treasury, or any government agency. A nursing home shall neither retaliate, nor discriminate, because of information lawfully provided to these authorities, because of a person's cooperation with them, or because a person is subpoenaed to testify at a hearing involving one of these authorities.

(15) Each nursing home shall adopt safety policies for the protection of residents from accident and injury.

(16) Each nursing home shall post whether they have liability insurance, the identity of their primary insurance carrier, and if self-insured, the corporate entity responsible for payment of any claims. It shall be posted on a sign no smaller than eleven inches (11") in width and seventeen inches (17") in height and displayed at the main public entrance.

(17) Documentation pertaining to the payment agreement between the nursing home and the resident shall be completed prior to admission. A copy of the documentation shall be given to the resident and the original shall be maintained in the nursing home records.

(18) The nursing home shall ensure a framework for addressing issues related to care at the end of life.

(19) The nursing home shall provide a process that assesses pain in all patients. There shall be an appropriate and effective pain management program.

(20) The nursing home shall carry out the following functions, all of which shall be documented in a written medical equipment management plan:

(a) Develop and maintain a current itemized inventory of medical equipment used in the facility, that is owned or leased by the operator of the facility;

(b) Develop and maintain a schedule for the maintenance, inspection and testing of medical equipment according to manufacturers' recommendations or other generally accepted standards. The schedule shall include the date and time such maintenance, inspection and testing was actually performed, and the name of the individual who performed such tasks; and

(c) Ensure maintenance, inspection and testing were conducted by facility personnel adequately trained in such procedures or by a contractor qualified to perform such procedures.

(21) All health care facilities licensed pursuant to T.C.A. §68-11-201, et. seq. shall post on a sign no smaller than eight and one-half inches (8½") in width and eleven inches (11") in height the following in the main public entrance:

(a) a statement that any person, regardless of age, who may be the victim of domestic violence may call the nationwide domestic violence hotline, with that number printed in boldface type, for immediate assistance.

(22) "No Smoking" signs or the international "No Smoking" symbol, consisting of a pictorial representation of a burning cigarette enclosed in a red circle with a red bar across it, shall be clearly and conspicuously posted at every entrance.

(Rule 1200-08-06-.04, continued)

(23) Residents of the facility are exempt from the smoking prohibition. The resident smoking practices shall be governed by the policies and procedures established by the facility. Smoke from such areas shall not infiltrate into the areas where smoking is prohibited.

(24) The facility shall develop a concise statement of its charity care policies and shall post such statement in a place accessible to the public.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 39-17-1803, 39-17-1804, 39-17-1805, 68-11-202, 68-11-204, 68-11-206, 68-11-209, 68-11-225, 68-11-254, 68-11-256, 68-11-257, 68-11-268, 68-11-906, and 71-6-121.* ***Administrative History:*** *Original rule filed March 27, 1975; effective April 25, 1975. Repeal and new rule filed July 14, 1983; effective August 15, 1983. Amendment filed May 24, 1985; effective June 23, 1985. Amendment filed March 13, 1986; effective April 12, 1986. Amendment filed October 22, 1987; effective December 6, 1987. Amendment filed May 10, 1990; effective June 24, 1990. Amendment filed March 9, 1992; effective April 23, 1992. Amendment filed March 10, 1995; effective May 24, 1995. Amendment filed June 13, 1997; effective August 27, 1997. Repeal and new rule filed January 31, 2000; effective April 15, 2000. Amendment filed June 18, 2002; effective September 1, 2002. Amendment filed May 24, 2004; effective August 7, 2004. Amendment filed February 23, 2007; effective May 9, 2007. Amendment filed July 18, 2007; effective October 1, 2007. Amendment filed February 22, 2010; effective May 23, 2010.*

1200-08-06-.05 ADMISSIONS, DISCHARGES, AND TRANSFERS.

(1) Every person admitted for care or treatment shall be under the supervision of a physician who holds a license in good standing to practice in Tennessee. The name of the resident's attending physician shall be recorded in the resident's medical record. The nursing home shall not admit the following types of residents:

(a) Persons who pose a clearly documented danger to themselves or to other residents in the nursing home.

(b) Children under fourteen (14) years of age, except when the department has approved the admission of a specific child.

(c) Persons for whom the nursing home is not capable of providing the care ordered by the attending physician. Documentation of the reason(s) for refusal of the admission shall be maintained.

(2) A diagnosis must be entered in the admission records of the nursing home for every person admitted for care or treatment.

(3) Prior to the admission of a resident to a nursing home or prior to the execution of a contract for the care of a resident in a nursing home (whichever occurs first), each nursing home shall disclose in writing to the resident or to the resident's guardian, conservator or representative, if any, whether the facility has liability insurance and the identity of the primary insurance carrier. If the facility is self-insured, their statement shall reflect that fact and indicate the corporate entity responsible for payment of any claims.

(4) Any residential facility licensed by the board of licensing health care facilities shall upon admission provide to each resident the division of adult protective services' statewide toll-free number: 888-277-8366.

(5) Facilities utilizing secured units must be able to provide survey staff with twelve (12) months of the following performance information specific to the secured unit and its residents:

* If a roll-call vote was necessary, the vote by the Agency on these rulemaking hearing rules was as follows:

Board Member	Aye	No	Abstain	Absent	Signature (if required)
Carissa S. Lynch, Pharm.D.	X				
Michael R. Miller				X	
Diana L. Miller	X				
Robert Gordon				X	
John A. Marshall	X				
Jennifer Gordon-Maloney, DDS	X				
Kenneth R. Robertson, M.D.	X				
Sherry Robbins, M.D.	X				
Annette Marlar				X	
Robert C. Breeden	X				
Roger L. Mynatt	X				
Janet Williford	X				
David Rhodes	X				
Joshua A. Crisp	X				
Betty S. Hodge	X				
Bobby Wood	X				
Jim Shulman	X				

I certify that this is an accurate and complete copy of rulemaking hearing rules, lawfully promulgated and adopted by the Board for Licensing Health Care Facilities (board/commission/ other authority) on 01/21/2015 (mm/dd/yyyy), and is in compliance with the provisions of T.C.A. § 4-5-222.

I further certify the following:

Notice of Rulemaking Hearing filed with the Department of State on: *11/07/14 (mm/dd/yy)*

Rulemaking Hearing(s) Conducted on: (add more dates). *01/21/15 (mm/dd/yy)*

Date: 10-6-2015

Signature:

Name of Officer: Devin M. Wells

Title of Officer: Deputy General Counsel, Department of Health

Subscribed and sworn to before me on:

Notary Public Signature:

My commission expires on:

SUZANNE MECHKOWSKI NOTARY PUBLIC STATE OF TENNESSEE SUMNER COUNTY MY COMMISSION EXPIRES APRIL 19, 2017

Board for Licensing Health Care Facilities Rules
Rules 1200-08-06-.04
Standards for Nursing Homes
Administration

All rulemaking hearing rules provided for herein have been examined by the Attorney General and Reporter of the State of Tennessee and are approved as to legality pursuant to the provisions of the Administrative Procedures Act, Tennessee Code Annotated, Title 4, Chapter 5.

Herbert H. Slatery III
Attorney General and Reporter

10/14/2015
Date

Department of State Use Only

Filed with the Department of State on: 10-20-15

Effective on: 1-18-16

Tre Hargett
Secretary of State

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G.O.C. STAFF RULE ABSTRACT

DEPARTMENT:	Finance and Administration
DIVISION:	Bureau of TennCare
SUBJECT:	TennCare Long Term Care Programs
STATUTORY AUTHORITY:	Tennessee Code Annotated, Sections 71-5-105 and 71-5-109
EFFECTIVE DATES:	January 21, 2016 through June 30, 2016
FISCAL IMPACT:	None.
STAFF RULE ABSTRACT:	The rulemaking hearing rules replace emergency rules that expire on January 23, 2016, which were promulgated to make assisted care living facilities services (ACLFs) available to persons in CHOICES 3. These rules add Community Living Supports (CLS) and Community Living Supports –Family Model (CLS-FM) to the array of services available as community-based residential alternatives (CBRAs). The emergency rules did not receive the necessary number of votes to receive a recommendation during the Committee's September 16, 2015, meeting.

Regulatory Flexibility Addendum
Pursuant to T.C.A. §§ 4-5-401 through 4-5-404, prior to initiating the rule making process as described in T.C.A. § 4-5-202(a)(3) and T.C.A. § 4-5-202(a), all agencies shall conduct a review of whether a proposed rule or rule affects small businesses.

The rules are not anticipated to have an effect on small businesses.

Impact on Local Governments

Pursuant to T.C.A. §§ 4-5-220 and 4-5-228 "any rule proposed to be promulgated shall state in a simple declarative sentence, without additional comments on the merits of the policy of the rules or regulation, whether the rule or regulation may have a projected impact on local governments." (See Public Chapter Number 1070 (http://state.tn.us/sos/acts/106/pub/pc1070.pdf) of the 2010 Session of the General Assembly)

The rules are not anticipated to have an impact on local governments.

Public Hearing Comments

One copy of a document containing responses to comments made at the public hearing must accompany the filing pursuant to T.C.A. § 4-5-222. Agencies shall include only their responses to public hearing comments, which can be summarized. No letters of inquiry from parties questioning the rule will be accepted. When no comments are received at the public hearing, the agency need only draft a memorandum stating such and include it with the Rulemaking Hearing Rule filing. Minutes of the meeting will not be accepted. Transcripts are not acceptable.

Comments: Tennessee Disability Coalition and Response from the Bureau of TennCare

Thank you for your comments regarding the Notice of Rulemaking Hearing for Community Based Residential Services, including primarily Community Living Supports and Community Living Supports-Family Model. We have carefully reviewed and considered each of your comments and suggestions. Please find attached a summary of your comments, along with the response to each. Where appropriate, adjustments have been made in the rule as documented in the summary.

TennCare Response to Comments on Rule 1200-13-01-.05

Rule Citation	Rule Language	Commenter	Comment(s)	Response
1200-13-01-.05	Paragraph (8) new Subparagraph (p) 2. Requirements for CBRAs (i) Member Choice (ii) Member Rights	The Tennessee Disability Coalition	Member Rights and Choice – The proposed rules reflect a respect for individual rights and choice. Protecting these rights and implementing processes that allow the exercise of choice and rights can be challenging. Throughout, we believe that family members and/or other representatives chosen by the member should be included planning, choice, and decision-making. The principles of family-centered care and supported decision-making should be reflected in the rules. In addition, with respect to choice, we believe those choices must be real and reasonable, and free of undue pressure. We are concerned that individuals have access to choices of location and situations that keep them in their preferred community and near natural and community supports.	The Home and Community-Based Services (HCBS) Regulations (specifically 42 C.F.R. § 441.301(c)(1)) issued by CMS establishes person-centered planning requirements for home and community-based settings in Medicaid HCBS programs. In this final rule, CMS specifies that service planning for participants in Medicaid HCBS programs must be developed through a person-centered planning process. The federal regulations require that, "The individual will lead the person-centered planning process where possible. The individual's representative should have a participatory role, as needed and as defined by the individual, unless State law confers decision-making authority to the legal representative. All references to individuals include the role of the individual's representative. In addition to being led by the individual receiving services and supports, the person-centered planning process: (i) Includes people chosen

				by the individual. (ii) Provides necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions..." The TennCare rules were written to ensure compliance with the Home and Community-Based Services (HCBS) Settings Final Rule and do not preclude an individual from including others of their choosing to participate in the planning process. Based on your comments, we have added language in 1200-13-01-.05(8)(p)2.(iii)(XI) and 1200-13-01-.05(8)(p)2.(v) and (vi) to further clarify the member's ability to include family members and others in the planning and decision making processes and to be supported by family members and others in exercising legal capacity. Additionally, in response to your comments, we have added language in 1200-13-01-.05(8)(p)2.(i)(III) to further emphasize your concerns regarding consideration of the member's preferred community and proximity to family and other natural supports.
1200-13-01-.05	Paragraph (8) new Subparagraph (p) 3. CLS Ombudsman	The Tennessee Disability Coalition	CLS Ombudsman – The Coalition strongly supports Members' access to Ombudsman services. We believe the CLS Ombudsman Program should be integrated into the existing state Long-Term Care Ombudsman Program. As defined at 1200-13-01-.02 (79), the LTC ombudsman already	The existing Long-Term Care Ombudsman funded through the Older American's Act (OAA) is designated to serve residents of licensed long-term care facilities. Currently, in the state of Tennessee, these include: nursing facilities, assisted care living facilities, and adult care homes. The state is prohibited from

			has a role on behalf of person residing in CBRA settings. A separate Ombudsman Program would be unnecessarily confusing. Additionally, because the existing program is established under the Older American Act, integrating the CLS Ombudsman into the existing Long-Term Care Ombudsman program will assure its integrity and independence of the Program.	using OAA funds to serve individuals receiving long term services and supports in their own home. However, TennCare could contract with the LTS Ombudsman Program to provide these services. As you know, we have held meetings with stakeholders to discuss a broader approach to Ombudsman services for individuals receiving HCBS. Those discussions yielded support as well as opposition for leveraging the current Ombudsman program for HCBS. A final decision regarding a comprehensive Ombudsman strategy has not been reached. In the interim, the Bureau of TennCare has contracted with the Area Agencies on Aging and Disability (AAAD) – a well-known community resource and advocate for older adults and individuals with disabilities that is independent from TennCare – to serve as CLS Ombudsman for members receiving the CLS and CLS-FM benefits. In their capacity as CLS Ombudsman, the AAAD will be responsible for: (1) Educating CHOICES members on CLS and CLS-FM services and the role of the CLS Ombudsman; (2) Conducting a pre-transition meeting with CHOICES members, during which the CLS Ombudsman will ensure that members are aware of their rights regarding choice and control in the CLS and CLS-FM service and that members understand how and when to contact the CLS Ombudsman; (3)

				Conducting CLS and CLS-FM transition surveys with CHOICES members prior to and after their transitions to CLS and CLS-FM residences; and (4) Providing ongoing assistance and advocacy for these members while receiving the service and systems level advocacy related to the CLS/CLS-FM service statewide.
1200-13-01-.05	Paragraph (8) new Subparagraph (p) 7. Reimbursement of CLS and CLS-FM Services	The Tennessee Disability Coalition	Reimbursement of CLS and CLS-FM Services – An issue not addressed in the rules, but about which we are concerned, is related to subparagraph (p) 7. Families and individuals have expressed concern about freedom of movement for Members receiving CLS. There needs to be a mechanism for a member to be away from home, for example making overnight visits to family or friends, without putting a provider at financial risk. Without such a mechanism, there is sometimes pressure to prevent such activity.	We agree that members should have freedom to be away from home, including overnight visits. In response to your comments, language has been added at 1200-13-01-.05(8)(p)5.(xii) and 1200-13-01-.05(8)(p)6.(xii)to reflect this choice. TennCare cannot, however, provide reimbursement for CLS or CLS-FM services that are not provided. Medicaid funds can only be used to reimburse approved Medicaid services that have been provided. If an individual is spending time away from their CLS residence to be with family and the provider is not providing services, the provider is not entitled to reimbursement. To reimburse a provider for services not rendered would constitute fraud under the False Claims Act. This has also been clarified at 1200-13-01-.05(8)(p)7.(ii).

Comments: Tennessee Justice Center and Response from the Bureau of TennCare

Thank you for your comments regarding the Notice of Rulemaking Hearing for Community Based Residential Services, including primarily Community Living Supports and Community Living Supports-Family Model. We have carefully reviewed and considered each of your comments and suggestions. Please find attached a summary of your comments, along with the response to each. Where appropriate, adjustments have been made in the rule as documented in the summary.

TennCare Response to Comments on Rule 1200-13-01-.05

Rule Citation	Rule Language	Commenter	Comment(s)	Response
1200-13-01-.05	Paragraph (8) new Subparagraph (p) 2. Requirements for CBRAs (iii) Member Choice (iv) Member Rights	Tennessee Justice Center	Member Choice – The proposed regulations empower only the member or his or her legal representative to exercise choice, without providing the member a right to consult family members or other advocates. We would recommend that the Bureau adopts a supported decision making model to provide members the supports they may require to exercise their legal capacity.	The Home and Community-Based Services (HCBS) Regulations (specifically 42 C.F.R. § 441.301(c)(1) issued by CMS establishes requirements for person-centered planning in Medicaid HCBS programs. In this final rule, CMS specifies that service planning for participants in Medicaid HCBS programs must be developed through a person-centered planning process. The federal regulations require that, "The individual will lead the person-centered planning process where possible. The individual's representative should have a participatory role, as needed and as defined by the individual, unless State law confers decision-making authority to the legal representative. All references to individuals include the role of the individual's representative. In addition to being led by the individual receiving services and supports, the person-centered planning process: (i) Includes people chosen by the individual. (ii) Provides necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions..." The TennCare rules were written to ensure compliance with the Home and Community-Based Services (HCBS) Settings Final Rule and do not preclude an individual from including others of their choosing to participate in the planning process.

				Based on your comments, we have added language in 1200-13-01-.05(8)(p)2.(iii)(XI) and 1200-13-01-.05(8)(p)2.(v) and (vi) to further clarify the member's ability to include family members and others in the planning and decision making processes and to be supported by family members and others in exercising legal capacity.
1200-13-01-.05	Paragraph (8) new Subparagraph (p) 2. Requirements for CBRAs (i) Member Choice (ii) Member Rights	Tennessee Justice Center	Family Involvement – The current regulations provide only the member or legal representative any meaningful involvement in the selection of the CBRA provider, housemates, and staff.	See above.
1200-13-01-.05	Paragraph (8) new Subparagraph (p) 2. Requirements for CBRAs (i) Member Choice	Tennessee Justice Center	Freedom of Movement – Members should be afforded a window of time after moving to the CBRA setting to change their minds and return to previous care setting. For residents transitioning from nursing facilities, this would include a bed hold for therapeutic leave while the member finalizes his or her decision to transition to CBRA.	In the CHOICES program, individuals who qualify for nursing facility level of care have the right to choose where they receive their care. So long as their needs can be safely met, they can choose to receive their care in their home, or in another place in the community (like and assisted living facility or a CLS home), or in a nursing facility. A CHOICES member that meets nursing facility level of care is free to choose their care setting (including returning to a nursing facility) at any time. No particular window of time can be applied. Based on your comments, additional language has been added at 1200-13-01-.05(8)(p)2.(ii) to further clarify this choice. However, it would not be appropriate to reimburse a NF for a bed hold once a member has transitioned

				into a CBRA. Pursuant to TennCare Rule 1200-13-01-.03(9)(a)1., the first condition for reimbursement of a nursing facility bed hold is that the resident intends to return to the NF. Instances in which a member has chosen to transition to a CLS home do not meet this condition. As stated above, should the member choose to return to the NF, they are free to do so as long as they continue to meet NF level of care.
1200-13-01-.05	Paragraph(8) new Subparagraph (p) 5. Requirements for Community Living Supports (v) lease agreement 6. Requirements for Community Living Supports Family Model (CLS-FM) Services (v) lease agreement	Tennessee Justice Center	Lease requirements – To fully ensure that members may leave a care setting they do not find optimal for their needs, the regulations should permit members to leave with limited notice requirements under specific circumstances, such as a window after admission, after a staffing change, or after a substantial change to the member's care plan.	The Home and Community-Based Services (HCBS) Regulations (specifically 42 C.F.R. § 441.301(c)(4)-(6)) issued by CMS also establishes requirements for home and community-based settings in Medicaid HCBS programs. Included in this rule are requirements that provider-owned or provider-controlled residential settings include provisions that: 1) the specific unit/dwelling is owned, rented, or occupied under legally enforceable agreement and 2) affords the individual the same responsibilities/protections from eviction as all tenants under landlord tenant law of state, county, city or other designated entity OR if tenant laws do not apply, state ensures lease, residency agreement or other written agreement is in place providing protections to address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law. The lease provisions included in the TennCare rule are required by CMS and ensure the member's legal protections are the same as other Tennesseans not receiving

				Medicaid reimbursed long-term services and supports. This includes a member's ability to terminate a lease. Further, as noted above, a CHOICES member that meets nursing facility level of care is free to choose their care setting at any time. This could include any of the specific circumstances identified. In addition, we do not want a member to have to move as a result of a staffing change. Per the HCBS Setting and PCP final rule, members will have a say in who provides their services. Therefore, part of the purpose of requiring a lease arrangement is to help ensure continuity of the member's residence even when staff may need to change.
1200-13-01-.05	Paragraph(8) new Subparagraph (p) 3. CLS Ombudsman	Tennessee Justice Center	CLS Ombudsman – Request clarification on how the CLS Ombudsman's services are advertised and made available to members. We recommend that each provider is required to prominently post the contact information for the CLS Ombudsman, provide meaningful access to telephones, and provide private space to meet with the CLS Ombudsman at the provider site.	The Bureau of TennCare has contracted with the Area Agencies on Aging and Disability (AAAD) to serve as CLS Ombudsman for members receiving the CLS and CLS-FM benefits. In their capacity as CLS Ombudsman, the AAAD will be responsible for: (1) Educating CHOICES members on CLS and CLS-FM services and the role of the CLS Ombudsman; (2) Conducting a pre-transition meeting with CHOICES members, during which the CLS Ombudsman will ensure that members are aware of their rights regarding choice and control in the CLS and CLS-FM service and that members understand how and when to contact the CLS Ombudsman; (3) Conducting CLS and CLS-FM transition surveys with CHOICES members prior to and after their transitions to CLS and CLS-FM residences; and (4)

				Providing ongoing assistance and advocacy for these members while receiving the service and systems level advocacy related to the CLS/CLS-FM service statewide. While we appreciate the importance of ensuring that individuals are aware of how to contact the CLS Ombudsman, requiring the information to be posted in individuals' homes infringes on individuals' rights to decorate their homes as they see fit and feels institutional in nature. Therefore, posting such information has been left to the discretion of the individual. 1200-13-01-.05(8)(p)3.(ii)(II) sets forth the responsibility of the Ombudsman to ensure that the Member knows how to contact the Ombudsman. In response to your comments, additional language has been added in 1200-13-01-.05(8)(p)3.(iii) and (iv) regarding the responsibility of the CLS or CLS-FM provider to ensure that CHOICES members receiving these services know how to contact the Ombudsman and that contact information is available in the residence in the location of the Member's preference, and which reinforces the right to privacy afforded to members under the HCBS Regulations (referenced above and elaborated in the Settings Compliance Requirement Toolkit developed by CMS), to include access to telephones and computers and to communicate in private, including while

				meeting with the Ombudsman.
1200-13-01-.05	Paragraph(8) new Subparagraph (p) 5. Requirements for Community Living Supports (i) Providers of CLS services in the CHOICES program shall: (V) Comply with background check requirements 6. Requirements for Community Living Supports Family Model (CLS-FM) Services (i) Providers of CLS-FM services in the CHOICES program shall: (V) Comply with background check requirements	Tennessee Justice Center	Background Checks – The regulations do not specifically outline the background check requirements for CLS and CLS-FM providers, including who would be subject to background checks and when such checks must be completed.	Sections #5 and #6 of paragraph (8) subparagraph (p) of the proposed rule (referenced in the second column) include requirements that CLS and CLS-FM providers comply with background check requirements specified in T.C.A. Title 33. Title 33, Chapter 2, Part 12 (33-2-1202), each facility or service licensed under chapter 2, part 4 of this title shall have a criminal background check performed on each employee whose responsibilities include direct contact with or direct responsibility for service recipients within ten (10) days of employment or within ten (10) days of a change in responsibilities that includes direct contact with or direct responsibility for service recipients.

1200-13-01-.05		Tennessee Justice Center	Staffing Change – We recommend the Bureau provide members notice and opportunity to change care settings or providers if there is a staffing change at a CLS or CLS-FM provider.	TennCare agrees that member choice in staff and consistency in provider staffing have significant impact on the quality from the member's perspective. Unfortunately, staffing changes do not always allow time for advance notice. Additionally, there are circumstances where allowing the worker to continue working is prohibited such as allegations of abuse, neglect, and exploitation. In response to your comments, language has been added at 1200-13-01-.05(8)(p)5.(iii)(I) and (II) to provide for notification when possible, as well as opportunity to assist in selecting new staff.

Comments: Tennessee Health Care Association (THCA) and Response from the Bureau of TennCare

Thank you for your comments regarding the Notice of Rulemaking Hearing for Community Based Residential Services, including primarily Community Living Supports and Community Living Supports-Family Model. We have carefully reviewed and considered each of your comments and suggestions. Please find attached a summary of your comments, along with the response to each. Where appropriate, adjustments have been made in the rule as documented in the summary.

TennCare Response to Comments on Rule 1200-13-01-.02 and .05

Rule Citation	Commenter	Comment(s)	Response
1200-13-01-.02 and .05	Tennessee Health Care Association / Tennessee Center for Assisted Living	General comments regarding the legislative and legal authority for CLS Rules. A. Authority for Rulemaking and Oversight of CLS	T.C.A. § 33-2-418(c), passed by the General Assembly in 2012, provides authority for a residential facility or provider licensed by the department of intellectual and developmental disabilities to also provide residential services to the elderly or adults with physical disabilities.

		Homes B. Use of Emergency Rule Process	The practice of nursing, including nurses who might perform skilled nursing services for individuals receiving CLS or CLS-FM services is regulated by the board of nursing as set forth in T.C.A. Title 63, Chapter 7. This is not an Emergency Rule. As described in the Emergency Rule Filing Form, T.C.A. § 4-5-208(4) permits an agency to adopt an emergency rule when it is required by an agency of the federal government and the adoption of the rule through ordinary rulemaking procedure might jeopardize the loss of federal funds.
1200-13-01-.02 and .05	Tennessee Health Care Association / Tennessee Center for Assisted Living	The scope of services allowed in the identified DIDD licensure regulations are not sufficient to provide for the needs of the CLS target population and, specifically CLS 3 recipients.	Providers licensed under the applicable licensure requirements currently serve residents enrolled in Section 1915(c) waivers with needs that are commensurate with the CLS target population, including individuals who may qualify for CLS-3 reimbursement. Individuals who require health care services in addition to assistance with personal care are entitled pursuant to the Americans with Disabilities Act to receive services in the most integrated setting appropriate, and cannot be restricted, on the basis of their disability, only to services in an institution, i.e., nursing facility.
1200-13-01-.02 and .05	Tennessee Health Care Association / Tennessee Center for Assisted Living	Proposed life safety regulations may not adequately protect CLS recipients.	See comment above. Providers licensed under the applicable licensure requirements currently serve residents enrolled in Section 1915(c) waivers with mobility needs and cognitive limitations at least as significant as the CLS target population, including individuals who may qualify for CLS-3 reimbursement. As with health care services, individuals who need assistance with mobility or cognitive limitations cannot be restricted, on the basis of their disability, only to services in an institution, i.e., nursing facility.
1200-13-01-.05 Paragraph (8) new Subparagraph (p) 3. CLS Ombudsman	Tennessee Health Care Association / Tennessee Center for Assisted Living	CLS Ombudsman – THCA believes that the independence of the proposed ombudsman is essential to ensuring that patient choices of services is preserved and any conflicts of interest between beneficiaries, MCOs, case coordinators, and	Based on your comments, recommended language has been added in 1200-13-01-.05(8)(p)3.(i).

		TennCare are appropriately resolved. THCA recommends that the rule include language specifically recognizing that independence of that ombudsman such as, "The CLS Ombudsman shall be employed and/or contracted with an agency that is separate and distinct from the TennCare Bureau."	
1200-13-01-.05 Paragraph (8) new Subparagraph (p) 1. Intent	Tennessee Health Care Association / Tennessee Center for Assisted Living	Delineation of CLS requirements – THCA recommends either the rule specifically outline the requirements referenced in Paragraph (8), new Subparagraph (p), (1) or that a readily available listing and citation to the incorporated requirements be provided.	The Contractor Risk Agreement (CRA) between TennCare and the Managed Care Organizations is posted on TennCare's website. TennCare Provider Agreement requirements are also delineated in the CRA. All state laws and regulations are publicly available.
1200-13-01-.02 and .05	Tennessee Health Care Association / Tennessee Center for Assisted Living	Protections for beneficiaries choosing to reverse election of CLS – THCA recommends that TennCare adopt a provision that allows members to subsequently reverse their election of CLS without penalty.	In the CHOICES program, individuals have the right to choose where they receive their care. They can choose to receive their care in their home or in another place in the community like an assisted living facility or a CLS home. And, for individuals that meet nursing facility level of care, they can choose to receive their care in a nursing facility. A CHOICES member can request a change in their plan of care (and care setting) at any time. Members are never penalized for changing care settings. The TennCare waiver already permits TennCare to grant an exception for a person in the community seeking NF admission who continues to meet the NF LOC in place at the time of enrollment into CHOICES 1 when such person has transitioned to the community and requires readmission to the NF. In response to your comment, this will also be added to TennCare Rule 1200-13-01-.05(3)(b)4. Further, based on your comments, additional language has been added at 1200-13-01-.05(8)(p)2.(ii) to clarify this choice.
1200-13-01-.02 and .05	Tennessee Health Care Association / Tennessee Center for Assisted Living	Nursing Facility "safe discharge" issues – In instances where THCA member providers do not feel that the CLS setting provides a safe discharge	As THCA is aware, TennCare is not the State Survey Agency as specified in the State Medicaid Plan. TennCare cannot therefore provide interpretation of federal regulations which are carried out by the State Survey Agency in

		as required by federal regulations, THCA requests TennCare respond to those concerns by explaining whether for other regulatory purposes the facility can rely on the determination of TennCare and the MCO that the movement of the individual constitutes a "safe discharge." THCA recommends the inclusion of language in the rule at (p) (2) (III) stating,, "Any provider of services to a CHOICES beneficiary may accept the determination under this rule that the setting is appropriate for the individual to be sufficient to ensure the individual's placement is a safe and appropriate discharge."	accordance with the State Operations Manual and other federal guidance documents pertaining to federal survey requirements and processes. Nonetheless, the proposed rule makes clear that *"A Member shall transition into a specific CBRA setting and receive CBRA services only when…[t]he setting has been determined to be appropriate for the Member based on the Member's needs, interests, and preferences. A CLS or CLS-FM provider shall not admit a Member and CLS or CLS-FM services shall not be authorized for a CHOICES Member unless the CLS or CLS-FM provider is able to safely meet the Member's needs and ensure the Member's health, safety and well-being."* In addition, transition to CLS or CLS-FM does not relieve the NF of its responsibilities under the law to provide for other aspects of an appropriate discharge plan that are critical to the member's health and safety. For example, the NF might fail to ensure that the resident's clinical record is appropriately documented by the resident's physician. This could result in the CLS provider not being fully informed of the person's needs in order to properly evaluate the provider's ability to deliver appropriate supports. Further, notwithstanding the appropriateness of the CLS or CLS-FM provider and setting, the NF might also fail to provide proper orientation for transfer or discharge, for example, by failing to ensure that written discharge instructions are provided.

Department of State Division of Publications 312 Rosa L. Parks Avenue, 8th Floor Snodgrass/TN Tower Nashville, TN 37243 Phone: 615-741-2650 Email: publications.information@tn.gov	For Department of State Use Only Sequence Number: 10-17-15 Rule ID(s): 6063 File Date: 10/22/2015 Effective Date: 1/21/2016

Rulemaking Hearing Rule(s) Filing Form

Rulemaking Hearing Rules are rules filed after and as a result of a rulemaking hearing (Tenn. Code Ann. § 4-5-205).

Pursuant to Tenn. Code Ann. § 4-5-229, any new fee or fee increase promulgated by state agency rule shall take effect on July 1, following the expiration of the ninety (90) day period as provided in § 4-5-207. This section shall not apply to rules that implement new fees or fee increases that are promulgated as emergency rules pursuant to § 4-5-208(a) and to subsequent rules that make permanent such emergency rules, as amended during the rulemaking process. In addition, this section shall not apply to state agencies that did not, during the preceding two (2) fiscal years, collect fees in an amount sufficient to pay the cost of operating the board, commission or entity in accordance with § 4-29-121(b).

Agency/Board/Commission:	Tennessee Department of Finance and Administration
Division:	Bureau of TennCare
Contact Person:	George Woods
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Revision Type (check all that apply):

X Amendment
___ New
___ Repeal

Rule(s) Revised (**ALL** chapters and rules contained in filing must be listed here. If needed, copy and paste additional tables to accommodate multiple chapters. Please enter only **ONE** Rule Number/Rule Title per row)

Chapter Number	**Chapter Title**
1200-13-01	TennCare Long-Term Care Programs
Rule Number	**Rule Title**
1200-13-01-.02	Definitions
1200-13-01-.05	TennCare CHOICES Program

(Place substance of rules and other info here. Statutory authority must be given for each rule change. For information on formatting rules go to http://state.tn.us/sos/rules/1360/1360.htm)

Paragraph (28) of Rule 1200-13-01-.02 Definitions is deleted in its entirety and replaced with a new Paragraph (28) which shall read as follows:

(28) Community-Based Residential Alternatives (CBRA) to institutional care. For purposes of CHOICES:

(a) Residential services that offer a cost-effective, community-based alternative to NF care for individuals who are elderly and/or adults with Physical Disabilities.

(b) CBRAs include, but are not limited to:

1. Services provided in a licensed facility such as an ACLF or Critical Adult Care Home, and residential services provided in a licensed home or in the person's home by an appropriately licensed provider such as Community Living Supports or Community Living Supports-Family Model; and

2. Companion Care.

Rule 1200-13-01-.02 Definitions is amended by inserting in alphabetical order the following new Paragraphs, with all paragraphs numbered appropriately so that the new Paragraphs shall read as follows:

(#) Community Living Supports (CLS). For the purposes of CHOICES this service is available to CHOICES Group 2 and 3 Members as appropriate:

(a) A CBRA licensed by the DIDD in accordance with T.C.A. Title 33 and TDMHSAS Rules 0940-5-24, 0940-5-28 or 0940-5-32, as applicable, that encompasses a continuum of residential support options for up to four individuals living in a home that:

1. Supports each resident's independence and full integration into the community;

2. Ensures each resident's choice and rights; and

3. Comports fully with standards applicable to HCBS settings detailed in 42 C.F.R. § 441.301(c)(4) and (5), including those requirements applicable to provider-owned or controlled homes, as applicable, *including any exception as supported by the individual's specific assessed need and* set forth in the person-centered plan of care.

(b) CLS services are individualized based on the needs of each resident and specified in the person-centered plan of care. Services may include hands-on assistance, supervision, transportation, and other supports intended to help the individual exercise choices such as:

1. Selecting and moving into a home.

2. Locating and choosing suitable housemates.

3. Acquiring and maintaining household furnishings.

4. Acquiring, retaining, or improving skills needed for activities of daily living or assistance with activities of daily living as needed, such as bathing, dressing, personal hygiene and grooming, eating, toileting, transfer, and mobility.

5. Acquiring, retaining, or improving skills needed for instrumental activities of daily living or assistance with instrumental activities of daily living as needed, such as household chores, meal planning, shopping, preparation and storage of food, and managing personal finances.

6. Building and maintaining interpersonal relationships with family and friends.

7. Pursuing educational goals and employment opportunities.

8. Participating fully in community life, including faith-based, social, and leisure activities selected by the individual.

9. Scheduling and attending appropriate medical services.

10. Self-administering medications, including assistance with administration of medications as permitted pursuant to T.C.A. §§ 68-1-904 and 71-5-1414.

11. Managing acute or chronic health conditions, including nurse oversight and monitoring, and skilled nursing services as needed for routine, ongoing health care tasks, such as blood sugar monitoring and management, oral suctioning, tube feeding, bowel care, etc.

12. Becoming aware of, and effectively using, transportation, police, fire, and emergency help available in the community to the general public.

13. Asserting civil and statutory rights through self-advocacy.

(#) Community Living Supports Family Model (CLS-FM). For the purposes of CHOICES, this service is available to CHOICES Group 2 and 3 Members as appropriate:

(a) A CBRA licensed by the DIDD in accordance with T.C.A. Title 33 and TDMHSAS Rule 0940-5-26 that encompasses a continuum of residential support options for up to three individuals living in the home of trained family caregivers (other than the individual's own family) in an "adult foster care" arrangement. In this type of shared living arrangement, the provider allows the individual(s) to move into his or her existing home in order to integrate the individual into the shared experiences of a home and a family and provide the individualized services that:

1. Support each resident's independence and full integration into the community;

2. Ensure each resident's choice and rights; and

3. Support each resident in a manner that comports fully with standards applicable to HCBS settings detailed in 42 C.F.R. § 441.301(c)(4)-(5), including those requirements applicable to provider-owned or controlled homes, as applicable, including any exception as supported by the individual's specific assessed need and set forth in the person-centered plan of care.

(b) CLS-FM services are individualized based on the needs of each resident and specified in the person-centered plan of care. Services may include hands-on assistance, supervision, transportation, and other supports intended to help the individual exercise choices such as:

1. Selecting and moving into a home.

2. Locating and choosing suitable housemates.

3. Acquiring and maintaining household furnishings.

4. Acquiring, retaining, or improving skills needed for activities of daily living or assistance with activities of daily living as needed, such as bathing, dressing, personal hygiene and grooming, eating, toileting, transfer, and mobility.

5. Acquiring, retaining, or improving skills needed for instrumental activities of daily living or assistance with instrumental activities of daily living as needed, such as household chores, meal planning, shopping, preparation and storage of food, and managing personal finances.

6. Building and maintaining interpersonal relationships with family and friends.

7. Pursuing educational goals and employment opportunities.

8. Participating fully in community life, including faith-based, social, and leisure activities selected by the individual.

9. Scheduling and attending appropriate medical services.

10. Self-administering medications, including assistance with administration of medications as permitted pursuant to T.C.A. §§ 68-1-904 and 71-5-1414.

11. Managing acute or chronic health conditions, including nurse oversight and monitoring, and skilled nursing services as needed for routine, ongoing health care tasks, such as blood sugar monitoring and management, oral suctioning, tube feeding, bowel care, etc.

12. Becoming aware of, and effectively using, transportation, police, fire, and emergency help available in the community to the general public.

13. Asserting civil and statutory rights through self-advocacy.

Statutory Authority: T.C.A. §§ 4-5-202, 71-5-105 and 71-5-109.

Rule 1200-13-01-.02 Definitions is amended by adding the phrase "and in CHOICES Community Living Supports-Family Model" after the word "CHOICES" in the current Paragraph (62) Immediate Family Member so that as amended the current Paragraph (62) shall read as follows:

(62) Immediate Family Member. For purposes of employment as a Consumer-Directed Worker in CHOICES and in CHOICES Community Living Supports-Family Model, a spouse, parent, grandparent, child, grandchild, sibling, mother-in-law, father-in-law, sister-in-law, brother-in-law, daughter-in-law, and son-in-law. Adopted and step Members are included in this definition.

Statutory Authority: T.C.A. §§ 4-5-202, 71-5-105 and 71-5-109.

Part 4 of Subparagraph (b) of Paragraph (3) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by adding a sentence at the end of the part so as amended Part 4 shall read as follows:

4. Members enrolled in CHOICES Group 1 on June 30, 2012, who wish to begin receiving HCBS and transition to CHOICES Group 2 shall, for purposes of LOC, be permitted to do so, so long as they continue to meet the NF LOC criteria in place on June 30, 2012, and have remained continuously enrolled in CHOICES Group 1 and in TennCare since June 30, 2012. Should such Member subsequently require transition back to CHOICES Group 1, TennCare may grant an exception to the current NF LOC criteria, so long as the person continues to meet the NF LOC criteria in place on June 30, 2012, and has remained continuously enrolled in CHOICES Group 1 and/or Group 2 and in TennCare since June 30, 2012.

Column 2 "Benefits for CHOICES 2 Members" of Part 4. CBRA of Subparagraph (l) of Paragraph (8) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with a new Part 4. which shall read as follows:

Service	Benefits for CHOICES 2 Members	Benefits for Consumer Direction ("Eligible HCBS")
4. CBRA	Companion Care. Not covered (regardless of payer), when the Member is living in an ACLF, Critical Adult Care Home, Residential Home for the Aged or other group residential setting, or receiving any of the following HCBS: Adult Day Care, CBRA services, or Short-Term NF Care.	Yes
	CBRA services (e.g., ACLFs, Critical Adult Care Homes, CLS, and CLS-FM).	No

Subparagraph (l) of Paragraph (8) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by adding a new Part 4. CBRA to the "Benefits for CHOICES 3 Members" chart and re-numbering the current Part 4. Home-Delivered Meals as 5. and subsequent parts re-numbered accordingly so as amended the new Part 4. shall read as follows:

Service	Benefits for CHOICES 3 Members	Benefits for Consumer Direction ("Eligible HCBS")
4. CBRA	*CBRA services (e.g., ACLFs, CLS, and CLS-FM as specified below).* CBRAs available to individuals in Group 3 include only Assisted Care Living Facility services, CLS, and CLS-FM that can be provided within the limitations set forth in the expenditure cap as defined in Rule 1200-13-01-.02 and further specified in Rule 1200-13-01-.05(4)(f), when the cost of such services will not exceed the cost of CHOICES HCBS that would otherwise be needed by the Member to 1) safely transition from a nursing facility to the community; or 2) continue being safely served in the community and to delay or prevent nursing facility placement.	*No*

Paragraph (8) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by adding a new Subparagraph (p) which shall read as follows:

(p) Community Based Residential Alternatives (CBRAs).

1. Intent. This subparagraph describes requirements for CBRAs in the CHOICES program necessary to ensure compliance with federal HCBS obligations, including those set forth in 42 C.F.R. §§ 441.301, et seq. These requirements supplement requirements set forth in the licensure rules applicable to the specific CBRA provider, requirements for Managed Care Organizations who administer CBRAs in the CHOICES program, requirements set forth in

MCO provider agreements with CBRA providers, and other applicable state laws and regulations, and program policies and protocols applicable to these services and/or providers of these services.

2. Requirements for CBRAs.

(i) Member Choice. A Member shall transition into a specific CBRA setting and receive CBRA services only when such services and setting:

(I) Have been selected by the Member;

(II) The Member has been given the opportunity to meet and to choose to reside with any housemates who will also live in the CBRA setting, as applicable; and

(III) The setting has been determined to be appropriate for the Member based on the Member's needs, interests, and preferences, including (as applicable) the member's preferred community and/or proximity to family and other natural supports. A CLS or CLS-FM provider shall not admit a Member and CLS or CLS-FM services shall not be authorized for a CHOICES Member unless the CLS or CLS-FM provider is able to safely meet the Member's needs and ensure the Member's health, safety and well-being.

(ii) A Member may choose to stop receiving services in a CBRA setting or from a particular CBRA provider at any time, and shall be supported in choosing and transitioning within a reasonable period to a different service, setting, or provider as applicable, that is appropriate based on the Member's needs and preferences.

(iii) Member Rights. Providers of CBRA services shall ensure that services are delivered in a manner that safeguards the following rights of persons receiving CBRA services:

(I) To be treated with respect and dignity;

(II) To have the same legal rights and responsibilities as any other person unless otherwise limited by law;

(III) To receive services regardless of gender, race, creed, marital status, national origin, disability, sexual orientation, ethnicity or age;

(IV) To be free from abuse, neglect and exploitation;

(V) To receive appropriate, quality services and supports in accordance with a comprehensive, person-centered written plan of care;

(VI) To receive services and supports in the most integrated and least restrictive setting that is appropriate based on the individualized needs of the Member;

(VII) To have access to personal records and to have services, supports and personal records explained so that they are easily understood;

(VIII) To have personal records maintained confidentially;

(IX) To own and have control over personal property, including personal funds, as specified in the plan of care;

(X) To have access to information and records pertaining to expenditures of funds for services provided;

(XI) To have choices and make decisions, and to be supported by family members, an advocate or others, as appropriate, to exercise their legal capacity;

(XII) To have privacy;

(XIII) To be able to associate, publicly or privately, with friends, family and others;

(XIV) To practice the religion or faith of one's choosing;

(XV) To be free from inappropriate use of physical or chemical restraint;

(XVI) To have access to transportation and environments used by the general public; and

(XVII) To seek resolution of rights violations or quality of care issues without retaliation.

(iv) The rights to be safeguarded by providers described in this rule do not limit any other statutory and constitutional rights afforded to all CHOICES Members or their legally authorized representatives, including those rights provided by the HCBS Settings Rule and Person-Centered Planning Rule in 42 C.F.R. § 441.301, and all other rights afforded to residents of CBRAs specific to the licensure authority for that CBRA.

(v) A Member who does not have a legally authorized representative may be supported by family members, an advocate or others as needed to exercise their legal capacity in a supported decision making model.

(vi) A Member may include family members and/or other representatives in the planning and decision-making processes.

(vii) A provider may serve as the Member's representative payee and assist the Member with personal funds management only as specified in the plan of care. Providers who assist the Member with personal funds management in accordance with the plan of care shall comply with all applicable policies and protocols pertaining to personal funds management, and shall ensure that the Member's bills have been paid timely and are not overdue, and that there are adequate funds remaining for food, utilities, and any other necessary expenses.

3. CLS Ombudsman.

(i) TennCare shall arrange for all Members choosing to receive CLS or CLS-FM services, including Members identified for transition to CLS or CLS-FM, to have access to a CLS Ombudsman. The CLS Ombudsman shall be employed and/or contracted with an agency that is separate and distinct from the TennCare Bureau.

(ii) The CLS Ombudsman will:

(I) Help to ensure Member choice in the selection of their CLS or CLS-FM benefit, provider, setting, and housemates;

(II) Provide Member education, including rights and responsibilities of Members receiving CLS or CLS-FM, how to handle quality and other concerns, identifying and reporting abuse and neglect, and the role of the CLS Ombudsman and how to contact the CLS Ombudsman;

(III) Provide Member advocacy for individuals receiving CLS or CLS-FM services, including assisting individuals in understanding and exercising personal rights, assisting Members in the resolution of problems and complaints regarding CLS or CLS-FM services, and referral to APS of potential instances of abuse, neglect or financial exploitation; and

(IV) Provide systems level advocacy, including recommendations regarding potential program changes or improvements regarding the CLS or CLS-FM benefit, and

immediate notification to TennCare of significant quality concerns.

(iii) CLS and CLS-FM providers shall ensure that every CHOICES Member receiving CLS or CLS-FM services knows how to contact the CLS Ombudsman and that contact information for the CLS Ombudsman is available in the residence in a location of the Member's preference.

(iv) CLS and CLS-FM providers shall ensure access to telephones and/or computers for purposes of communication, and shall respect and safeguard the member's right to privacy, including the Member's ability to meet privately with the CLS Ombudsman in the residence.

4. Person–centered Delivery of CLS and CLS-FM Services. A CLS or CLS-FM provider shall be responsible for the following:

(i) A copy of the plan of care for any Member receiving CLS or CLS-FM services shall be accessible in the home to all paid staff;

(ii) Staff shall meet all applicable training requirements as specified in applicable licensure regulations, TennCare regulations, contractor risk agreements with managed care organizations, provider agreements with managed care organizations, or in TennCare policy or protocol. Staff shall be trained on the delivery of person-centered service delivery, and on each Member's plan of care, including the risk assessment and risk agreement, as applicable, prior to being permitted to provide supports to that Member;

(iii) The CLS or CLS-FM provider shall implement the Member's plan of care and shall ensure that services are delivered in a manner that is consistent with the Member's preferences and which supports the Member in achieving his or her goals and desired outcomes;

(iv) The CLS or CLS-FM provider shall support the Member to make his or her own choices and to maintain control of his or her home and living environment;

(v) The Member shall have access to all common living areas within the home with due regard to privacy and personal possessions;

(vi) The Member shall be afforded the freedom to associate with persons of his/her choosing and have visitors at reasonable hours;

(vii) The CLS or CLS-FM provider shall support the Member to participate fully in community life, including faith-based, social, and leisure activities selected by the Member; and

(viii) There shall be an adequate food supply (at least 48 hours) for the Member that is consistent with the Member's dietary needs and preferences.

5. Requirements for Community Living Supports (CLS).

(i) Providers of CLS services in the CHOICES program shall:

(I) Be contracted with the Member's MCO for the provision of CLS services, licensed by the DIDD in accordance with T.C.A. Title 33 and TDMHSAS Rules 0940-5-24, 0940-5-28 or 0940-5-32 as applicable, and contracted by the DIDD to provide residential services pursuant to an approved Section 1915(c) waiver;

(II) Maintain an adequate administrative structure necessary to support the provision of CLS services;

(III) Demonstrate financial solvency as it relates to daily operations, including sufficient resources and liquid assets to operate the facility;

(IV) Maintain adequate, trained staff to properly support each CLS resident; the provider must comply with minimum staffing standards specified in licensure regulations, and ensure an adequate number of trained staff to implement each resident's plan of care, and meet the needs and ensure the health and safety of each resident, including the availability of back-up and emergency staff when scheduled staff cannot report to work;

(V) Comply with all background check requirements specified in T.C.A Title 33;

(VI) Comply with all critical incident reporting and investigation requirements set forth in state law, contractor risk agreements with managed care organizations, provider agreements with managed care organizations, or in TennCare policy or protocol; and

(VII) Cooperate with quality monitoring and oversight activities conducted by the DIDD under contract with TennCare to ensure compliance with requirements for the provision of CLS and to monitor the quality of CLS and CLS-FM services received.

(ii) A home where CLS services are provided shall have no more than four (4) residents, or fewer as permitted by the applicable licensure requirements.

(iii) The Member or the Member's representative (legally authorized or designated by Member) shall have a contributing voice in choosing other individuals who reside in the home where CLS services are provided, and the staff who provide the Member's services and supports.

(I) The CLS provider shall notify the Member and the Member's representative (as applicable) of changes of extended or permanent duration in the regularly assigned staff who will provide the Member's support. Such notification may be verbal or in writing. When practicable, such notification shall occur in advance of the staffing change.

(II) The CLS provider shall ensure that the Member and/or Member's representative has the opportunity to help choose new staff who will be regularly assigned to support the Member; however, this may not be possible in the short-term for situations where the change in staffing is of limited duration or is unexpected, e.g., due to illness, termination of employment, or abuse or neglect.

(iv) A CLS provider may deliver CLS services in a home where other CHOICES members receiving CLS reside. A CLS provider may also deliver CLS services in a home where CHOICES members receiving CLS reside along with individuals enrolled in a Section 1915(c) HCBS waiver program operated by the DIDD, when the provider is able and willing to provide supports in a blended residence, comply with all applicable program requirements, and meet the needs and ensure the health, safety and welfare of each resident.

(v) In instances when the CLS provider owns the Member's place of residence, the provider must sign a written lease/agreement pursuant to the Tennessee Uniform Landlord and Tenant Act (T.C.A. §§ 66-28-101, et seq.) as applicable per the county of residence. If the Tennessee Uniform Landlord and Tenant Act is not applicable to the county of residence, the provider must sign a written lease/agreement with the Member that provides the Member with the same protections as those afforded under the Tennessee Uniform Landlord and Tenant Act.

(vi) Unless the residence is individually licensed or inspected by a public housing agency utilizing the HUD Section 8 safety checklist, the residence shall be inspected, as required by TennCare, prior to the Member's transition to CLS services; the home where CLS services are provided must have an operable smoke detector and a second means of

egress, and all utilities must be working and in proper order.

(vii) The provider shall be responsible for the provision of all assistance and supervision required by program participants. Services shall be provided pursuant to the Member's person-centered plan of care and may include assistance with the following:

(I) Hands-on assistance with ADLs such as bathing, dressing, personal hygiene, eating, toileting, transfers and ambulation;

(II) Assistance with instrumental activities of daily living necessary to support community living;

(III) Safety monitoring and supervision for Members requiring this type of support as outlined in their person-centered plan of care; and

(IV) Managing acute or chronic health conditions, including nurse oversight and monitoring, administration of medications, and skilled nursing services as needed for routine, ongoing health care tasks such as blood sugar monitoring and management, oral suctioning, tube feeding, bowel care, etc., by appropriately licensed nurses practicing within the scope of their licenses, except as delegated in accordance with state law.

(viii) Medication administration shall be performed by appropriately licensed staff or by unlicensed staff who are currently certified in medication administration and employed by an HCBS waiver provider who is both licensed under T.C.A. Title 33 and contracted with DIDD to provide services through an HCBS waiver operated by DIDD, as permitted pursuant to T.C.A. §§ 68-1-904 and 71-5-1414.

(ix) Self-administration of medications is permitted for a person receiving CLS services who is capable of using prescription medication in a manner directed by the prescribing practitioner without assistance or direction. Staff intervention must be limited to verbal reminders as to the time the medication is due. The plan of care must document any training the person needs in order to self-administer medications and how it will be provided; storage, labeling and documentation of administration; oversight to ensure safe administration; and how medication will be administered during any time the person is incapable of self-administration.

(x) Services and supports for a Member receiving CLS shall be provided up to 24 hours per day based on the Member's assessed level of need as specified in the plan of care and approved level of CLS reimbursement. Members approved for 24 hours per day of CLS are not prohibited from engaging in independent activities.

(xi) Members approved for 24 hour support who are assessed to be capable of independent functioning may participate in activities of their choosing without the support of staff as specified in the plan of care and risk assessment and risk agreement.

(xii) Regardless of the level of CLS reimbursement a Member is authorized to receive, a Member may choose to be away from home without support of staff, e.g., for overnight visits, vacations, etc. with family or friends.

(xiii) The CLS provider shall be responsible for community transportation needed by the Member. The CLS provider shall transport the Member into the community or assist the Member in identifying and arranging transportation into the community to participate in activities of his choosing.

(xiv) The provider shall be responsible for assisting the Member in scheduling medical appointments and obtaining medical services, including accompanying the Member to medical appointments, as needed, and shall either provide transportation to medical services and appointments for the Member or assist the Member in arranging and

utilizing NEMT, as covered under the TennCare program.

6. Requirements for Community Living Supports Family Model (CLS-FM) Services.

(i) Providers of CLS-FM services in the CHOICES program shall:

(I) Be contracted with the Member's MCO for the provision of CLS-FM services, licensed by the DIDD in accordance with T.C.A. Title 33 and TDMHSAS Rule 0940-5-26, and contracted by the DIDD to provide residential services pursuant to an approved Section 1915(c) waiver;

(II) Maintain an adequate administrative structure necessary to support the provision of CLS-FM services;

(III) Demonstrate financial solvency as it relates to daily operations, including sufficient resources and liquid assets to operate the facility;

(IV) Ensure CLS-FM family caregivers are adequately trained to properly support each CLS resident; the provider must comply with minimum staffing standards specified in licensure regulations, and ensure an adequate number of family caregivers and trained staff as needed to implement each resident's plan of care, and meet the needs and ensure the health and safety of each resident, including the availability of back-up and emergency staff when scheduled staff cannot report to work;

(V) Comply with all background check requirements specified in T.C.A. Title 33;

(VI) Comply with all critical incident reporting and investigation requirements set forth in state law, contractor risk agreements with managed care organizations, provider agreements with managed care organizations, or in TennCare policy or protocol; and

(VII) Cooperate with quality monitoring and oversight activities conducted by the DIDD under contract with TennCare to ensure compliance with requirements for the provision of CLS and to monitor the quality of CLS and CLS-FM services received.

(ii) A home where CLS-FM services are provided shall serve no more than three (3) individuals, including individuals receiving CLS-FM services and individuals receiving Family Model Residential services, and must be physically adequate to allow each participant to have private bedroom and bathroom space unless otherwise agreed upon with residents to share, in which case each participant must have equal domain over shared spaces.

(iii) The Member or the Member's representative (legally authorized or designated by Member) shall have a contributing voice in choosing other individuals who reside in the home where CLS-FM services are provided, caregivers whose home the Member will move into, and any staff hired by the CLS-FM provider to assist in providing the Member's services and supports.

(iv) A CLS-FM provider may deliver CLS-FM services in a home where other CHOICES Members receiving CLS-FM reside. A CLS-FM provider may also deliver CLS services in a home where CHOICES Members receiving CLS-FM reside along with individuals enrolled in a Section 1915(c) HCBS waiver program operated by the DIDD, when the provider is able and willing to provide supports in a blended residence, comply with all applicable program requirements, and meet the needs and ensure the health, safety and welfare of each resident. In instances of blended homes, there shall be no more than three (3) service recipients residing in the home, regardless of the program or funding source.

(v) The family caregiver and Member must sign a written lease/agreement pursuant to the

Tennessee Uniform Landlord and Tenant Act (T.C.A. §§ 66-28-101, et seq.) as applicable per the county of residence. If the Tennessee Uniform Landlord and Tenant Act is not applicable to the county of residence, the provider must sign a written lease/agreement with the Member that provides the Member with the same protections as those afforded under the Tennessee Uniform Landlord and Tenant Act.

(vi) Unless the residence is individually licensed or inspected by a public housing agency utilizing the HUD Section 8 safety checklist, the residence shall be inspected, as required by TennCare, prior to the Member's transition to CLS services; the home where CLS-FM services are provided must have an operable smoke detector and a second means of egress.

(vii) The CLS-FM provider shall be responsible for the provision of all assistance and supervision required by program participants. Services shall be provided pursuant to the Member's person-centered plan of care and may include assistance with the following:

(I) Hands-on assistance with ADLs such as bathing, dressing, personal hygiene, eating, toileting, transfers and ambulation;

(II) Assistance with instrumental activities of daily living necessary to support community living;

(III) Safety monitoring and supervision for Members requiring this type of support as outlined in their person-centered plan of care; and

(IV) Managing acute or chronic health conditions, including nurse oversight and monitoring, administration of medications, and skilled nursing services as needed for routine, ongoing health care tasks such as blood sugar monitoring and management, oral suctioning, tube feeding, bowel care, etc., by appropriately licensed nurses practicing within the scope of their licenses, except as delegated in accordance with state law.

(viii) Medication administration shall be performed by appropriately licensed staff or by unlicensed staff who are currently certified in medication administration and employed by an HCBS waiver provider who is both licensed under T.C.A. Title 33 and contracted with DIDD to provide services through an HCBS waiver operated by DIDD, as permitted pursuant to T.C.A. §§ 68-1-904 and 71-5-1414.

(ix) Self-administration of medications is permitted for a person receiving CLS-FM services who is capable of using prescription medication in a manner directed by the prescribing practitioner without assistance or direction. Staff intervention must be limited to verbal reminders as to the time the medication is due. The plan of care must document any training the person needs in order to self-administer medications and how it will be provided; storage, labeling and documentation of administration; oversight to ensure safe administration; and how medication will be administered during any time the person is incapable of self-administration.

(x) Services and supports for a Member receiving CLS-FM shall be provided up to 24 hours per day based on the Member's assessed level of need as specified in the plan of care and approved level of CLS reimbursement. Members approved for 24 hours per day of CLS-FM are not prohibited from engaging in independent activities.

(xi) Members approved for 24 hour support who are assessed to be capable of independent functioning may participate in activities of their choosing without the support of staff as specified in the plan of care and risk assessment and risk agreement.

(xii) Regardless of the level of CLS-FM reimbursement a Member is authorized to receive, a Member may choose to be away from home without support of staff, e.g., for overnight visits, vacations, etc. with family or friends.

(xiii) The CLS provider shall be responsible for community transportation needed by the Member. The CLS provider shall transport the Member into the community or assist the Member in identifying and arranging transportation into the community to participate in activities of his choosing.

(xiv) The provider shall be responsible for assisting the Member in scheduling medical appointments and obtaining medical services, including accompanying the Member to medical appointments, as needed, and shall either provide transportation to medical services and appointments for the Member or assist the Member in arranging and utilizing non-emergency transportation services (NEMT), as covered under the TennCare program.

7. Reimbursement of CLS and CLS-FM Services

(i) Reimbursement for CLS and CLS-FM services shall be made to a contracted CLS or CLS-FM provider by the Member's MCO in accordance with the Member's plan of care and service authorizations, and contingent upon the Member's eligibility for and enrollment in TennCare and CHOICES.

(ii) Reimbursement for CLS and CLS-FM services shall be made only for dates of service that the member actually receives CLS and CLS-FM services. CLS and CLS-FM services shall not be reimbursed for any date on which the member does not receive any CLS or CLS-FM services because the member is in a hospital or other inpatient setting, or for therapeutic leave, e.g., overnight visits, vacations, etc. with family or friends when the Member is not accompanied by staff.

(iii) Rates of reimbursement for CLS and CLS-FM services shall be established by TennCare.

(iv) Rates of reimbursement for CLS and CLS-FM services may take into account the level of care the person qualifies to receive (Nursing Facility or At-Risk as determined by TennCare), and the person's support needs, including skilled nursing needs for ongoing health care tasks.

(v) The rate of reimbursement for CLS or CLS-FM, as applicable, shall not vary based on the number of people receiving CLS, CLS-FM or HCBS Waiver services who live in the home.

(vi) A licensed and contracted CLS or CLS-FM provider selected by a person to provide CLS or CLS-FM services shall determine whether the provider is able to safely provide the requested service and meet the person's needs, and may take into consideration the rate of reimbursement authorized.

(vii) Neither a Member nor a CLS or CLS-FM provider may file a medical appeal or receive a fair hearing regarding the rate of reimbursement a provider will receive for CLS or CLS-FM services.

(viii) The rate of reimbursement for CLS or CLS-FM services is inclusive of all applicable transportation services needed by the Member, except for transportation authorized and obtained under the TennCare NEMT benefit.

(ix) Reimbursement for CLS or CLS-FM services shall not be made for room and board. Residential expenses (e.g., rent, utilities, phone, cable TV, food, etc.) shall be apportioned as appropriate between the Member and other residents in the home.

(x) Family members of the individual receiving services are not prohibited from helping pay a resident's Room and Board expenses.

(xi) Reimbursement for CLS or CLS-FM services shall not include the cost of maintenance of the dwelling.

(xii) Reimbursement for CLS or CLS-FM services shall not include payment made to the Member's immediate family member as defined in Rule 1200-13-01-.02 or to the Member's conservator.

(xiii) Personal Care Visits, Attendant Care, and Home Delivered Meals shall not be authorized or reimbursed for a Member receiving CLS or CLS-FM services.

(xiv) In-home Respite shall not be authorized or reimbursed for a Member receiving CLS or CLS-FM services.

(xv) CLS and CLS-FM services shall not be provided or reimbursed in nursing facilities, ACLFs, hospitals or ICFs/IID.

Statutory Authority: T.C.A. §§ 4-5-202, 71-5-105 and 71-5-109.

I certify that this is an accurate and complete copy of rulemaking hearing rules, lawfully promulgated and adopted by the Tennessee Department of Finance and Administration (board/commission/ other authority) on 10/16/2015 (mm/dd/yyyy), and is in compliance with the provisions of T.C.A. § 4-5-222.

I further certify the following:

Notice of Rulemaking Hearing filed with the Department of State on: 08/11/2015

Rulemaking Hearing(s) Conducted on: (add more dates). 10/02/2015

Date: 10/16/15

Signature: Wendy Long MD

Name of Officer: Wendy J. Long, M.D., M.P.H.

Title of Officer: Deputy Director / Chief of Staff, Bureau of TennCare
Tennessee Department of Finance and Administration

KATHY CROCKARELL NOTARY PUBLIC STATE OF TENNESSEE DAVIDSON COUNTY

Subscribed and sworn to before me on: 10/16/2015

Notary Public Signature: Kathy Crockarell

My commission expires on: January 8, 2019

All rulemaking hearing rules provided for herein have been examined by the Attorney General and Reporter of the State of Tennessee and are approved as to legality pursuant to the provisions of the Administrative Procedures Act, Tennessee Code Annotated, Title 4, Chapter 5.

Herbert H. Slatery III

Herbert H. Slatery III
Attorney General and Reporter

10/21/2015
Date

Department of State Use Only

Filed with the Department of State on: 10/22/2015

Effective on: 1/21/2016

Tre Hargett
Secretary of State

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